the Canadian Nurse

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NURSING CARE STUDIES

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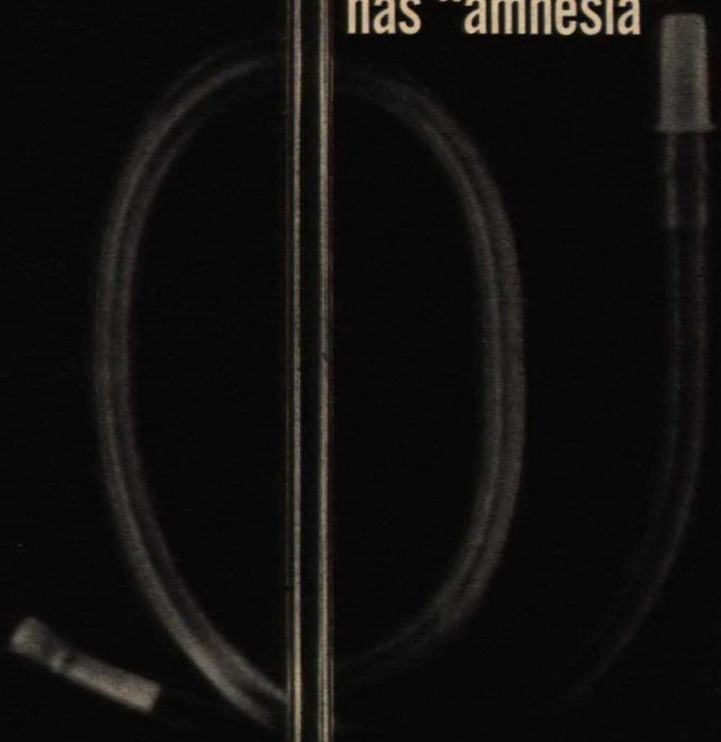

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Between Ourselves

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* * *

July is also the month when, as Canadian citizens, we honor the confederation of provinces that was effected 96 years ago. It is a very different world today. Communication in 1867 was a slow, tedious process that limited the spread of news. Travel by horse-drawn conveyances meant days instead of minutes between Toronto and Ottawa, for instance. Medical science was at the "frock coat" stage still awaiting the tremendous impetus of the twentieth century. Seven years would elapse before the first school for the training of nurses would be established in St. Catharines, Ontario.

Despite its vast area, Canada in 1867 was still a very small, immature country population-wise. Even by the turn of the century, the census revealed a total of only 5,371,315. Not until 1947 was the proud designation "Canadian" made a truly legal identity. Since that date thousands of persons of foreign birth have participated in formal Citizenship ceremonies.

The World of Nursing this month discusses some of the plans and proposals for special celebrations to mark Canada's Centennial year. Nationally, certain projects are under way. What is your local chapter considering? It is not too soon to start to plan.

* * *

We warmly commend to every reader the interesting, thought-provoking, soul-searching lead article which Mrs. M. BLANCHE DUNCANSON gave as her Keynote address at the 1963 convention of the Registered Nurses' Association of Ontario. While the College for Nurses has application only in Ontario, it is important that every nurse should be familiar with its role and functions. Mrs. Duncanson's clear exposition of the value of adequate communication has significance for *every* nurse.

* * *

Last May, the School for Graduate Nurses of McGill University, Montreal, for the first time in its forty-three year history, presented four graduate students at convocation, each of whom received her Master of Science (Applied). As one requirement each of these students made an intensive study of an appropriate problem in nursing. It is our hope that within the next few months we may be able to present condensations of some at least of their studies through our columns:

1. By Miss KATHLEEN DIER of Alberta: "A Survey of the Educational Programs in English Language Schools for Nursing Auxiliaries across Canada."

2. By Miss JEAN GODARD of Ontario: "A Study to Determine Opinions and Activities of a Group of Senior Students on Night Duty."

3. By Miss EVELYN ROCQUE of Alberta: "A Study of the Number and Reasons for and Head Nurses' Feelings about Patient Transfers in a Psychiatric Unit of a General Hospital."

4. By Miss CHARLOTTE CROWE of Saskatchewan: "A Study of Students' Opinions Respecting Field Work in the Final Year of the Baccalaureate Program in Nursing."

Pending the publication of these studies in condensed form, we have been advised that the complete reports will be available on loan from the McGill School for Graduate Nurses, 3506 University Street, Montreal 2, Que.

People talk about "having an aim in life." Have you one? It is your program for yourself that gives direction to your life . . . People get along better who form some definite idea of where they are going and what they are going to do. Mental pictures of the territory help you to find your way through it.

— *The Royal Bank of Canada Monthly Letter.*

THE CANADIAN NURSE

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Random Comments

Dear Editor:

In your March 1963 issue, I noticed a request for comments and suggestions regarding the magazine.

My personal comment of the magazine is that I find it dull and uninteresting with very few articles really worth reading. I am not alone in this view as I have discussed this matter with many nurses both English and Canadian trained. In fact, one nurse actually told me she never read the magazine and just threw it away without even opening it. I also object to the fact that there is no choice regarding subscription. Surely we are a mature enough group of women to decide for ourselves whether or not we wish to read a nursing journal.

More histories of interesting cases written by nurses with maybe a small cash prize for the ones chosen by the editorial staff would be a good idea. A question and answer column on non-medical problems could be included too, e.g. income tax, transfer of registration from one province to another, etc. as well as other difficulties that beset nurses during their careers.

I read the magazine because I paid for it, but I find many other publications more to my taste and much more stimulating.

(Mrs.) MARGARET MCDONALD,
S.R.N., R.F.N., S.C.M., Eng. R.N., Quebec.

** We welcome constructive criticism — and manuscripts — from our readers. Our objective is to make the magazine as informative and as interesting as possible. We cannot hope to please the subscriber who discards her magazine "without even opening it!"* — ED.

Dear Editor:

I have read with great interest many articles about the changes in nursing taking place today. I do hope the future trend and attitude of nursing will benefit from all this research, investigation and advice. With the changes and advancement of medical science, new educational programs are necessary. In this area nursing has progressed.

There is one aspect of medicine that will never change, but which seems sadly lacking in nursing of today. Although articles are written and students taught, there is no room left for kindness and understanding of the patient. He has become the experimental

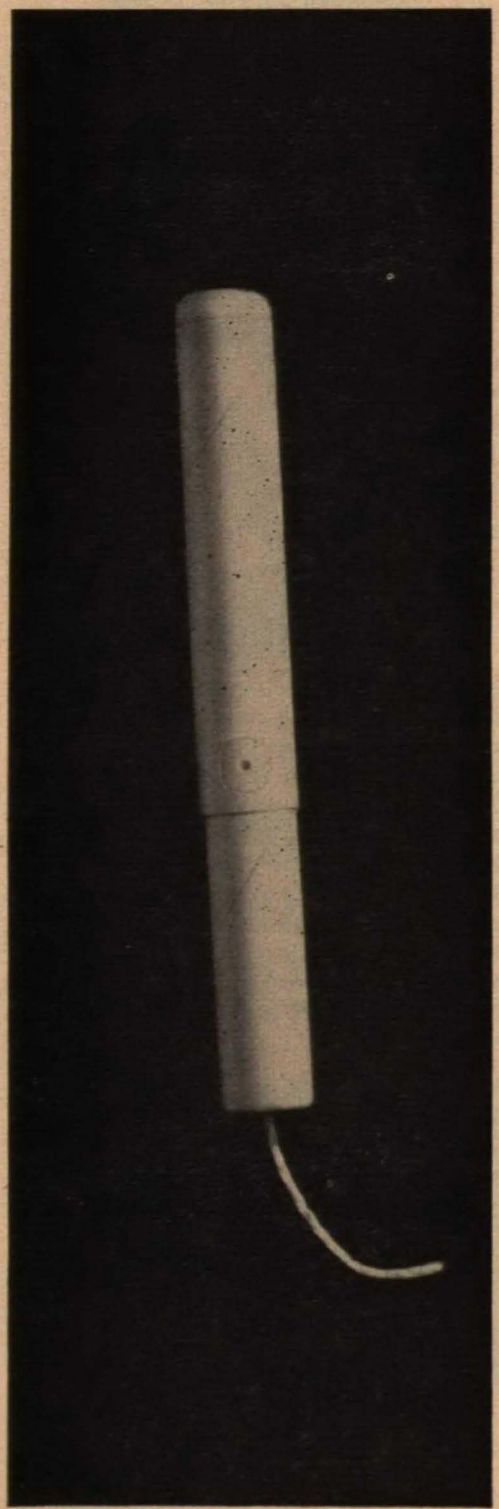
tool of nursing. We have been so concerned about keeping up with the modern rush and scurry of advancement that only in theory is the patient considered. In practice there is no time for him. This criticism is voiced frequently, and most people agree that the criticism is justified. It is then brushed aside to be dealt with in the future. First, we must train more nurses today! What sort of nurses will this produce? If there is no time for them to be concerned about the welfare of the patient today, what guarantee is there that they will be concerned tomorrow?

I think it is high time for us to stop and *think* what we are doing to nursing *today*. Raise the standards of nursing to produce nurses qualified to deal with increased technology — but let us not forget a patient is a person, badly in need of help.

Your articles on rehabilitation were most interesting. I became disabled, and it has been quite an experience. Time and again I was told assistance and help were available — I would have welcomed it, if this had been true! At first I did not feel disabled or incapable of helping myself. That I would have difficulty walking, I could accept. I also realized that life would be more of a challenge. But the odds are too great! Society will never let one forget that she is no longer a complete human being. In countless ways they point it out. Everyone has to tell you what to do. They expect you to accomplish the impossible: change your whole life, thinking, feelings, attitudes — everything. How? Well, that is my own problem! Financially, mentally, and physically! No one takes time to listen to these problems. You have to fit yourself into their prescribed moulds or they cannot help you. *This is not help!* I do not believe that beneficial help is available. Advice is often financially impossible to follow. A person's confidence is so completely undermined that she can no longer help herself. A point is reached where she is afraid to try.

One keeps hoping for a brighter day tomorrow, but we live today! Unless we stop to consider and *do* something about today, it seems like an empty hope. Talking about it is interesting but not terribly helpful if nothing comes of it. I know I am in no position to criticize nursing, as I find I can no longer continue as an active R.N. The pressures, strains, frustrations on top of this disability have been too much. I only wish people would stop and *think* of the effects this change in nursing has on patients.

R.N., Sask.



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THE CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED IN ENGLISH AND FRENCH
BY THE CANADIAN NURSES' ASSOCIATION

VOLUME 59 MONTREAL, JULY 1963 NUMBER 7

Who Speaks for Nurses and Nursing?

This is a time of unique opportunity for nurses and nursing, which may cease to exist if it is not seized with resolution. Evolution is preferred to revolution but our energies should not be allowed to dissipate as we plan for the advancement of nursing standards and service. I am tempted to advise you about the problems facing our profession and to define how they may be solved. The solution is, unfortunately, very elusive and very difficult to achieve since it involves our ability to communicate as individuals and as a group.

The powers of your elected representatives — the Board of the R.N.AO. — are derived from the membership. An informed, communicative membership has the responsibility of choosing representatives who are qualified by intelligence and integrity to deal with the perplexing issues which confront nursing. I am confident that there are those among you who are restless, hopeful, and wish to try your hands where others may not have achieved the hoped-for success. The opportunities are limitless when memberhip is informed about these issues so it can influence its representatives. Finally, membership must, through the channels of the annual meeting, approve or disapprove of the actions taken by the Board on its behalf. So, in the final analysis, *the awesome responsibility for nursing rests in the hands of each individual member*. How can she discharge this responsibility? Only when

Mrs. Duncanson, immediate past president of the Registered Nurses' Association of Ontario, is Director of the Nightingale School of Nursing, Toronto, Ont.

she communicates about nursing will there be a positive answer to the question, "Who speaks for Nurses and Nursing?"

As your president, I have had many opportunities to observe, study, and be involved in nursing at the level of trends. As these opportunities are not always available to each member, I invite you to take a serious, introspective look at the affairs of nursing.

The question I wish to place before you is not, "Should the R.N.A.O. speak for nurses and nursing?," but rather, "Does it?" To develop this topic I wish to substitute "communicate" for "speak," and in the context of this address, to identify the meaning of communication:

"communication" derives from the Latin "communicare," to make common, to share, to impart, to transmit. The interpretation of making common or sharing something among several persons or groups of persons is the preferred meaning. This definition stresses interaction and thus distinguishes a communication from a message. For example, we have recently received a message from the College of Nurses to renew our certificate of registration. The communication inherent in this message is the long history of securing registration in Ontario, the purpose of registration, the statutory responsibility, the influence of the Graduate Nurses' Association of Ontario, the Department of Health, the R.N.A.O., and the interactions between the members and the various publics involved.

(Ballard and Jarrett, Toronto)

BLANCHE DUNCANSON

Let us look at the general components of public communication. The initial component of the communicative process is an *idea or an impulse* in the mind of the sender. The second component is the *formal expression* of the idea which constitutes the message. The third component is the *receiver's interpretation* directly or indirectly received. The fourth component consists of the *receiver's response* to the message. This results in reactions which may or may not come to the attention of the original message sender. If they do, they constitute a fifth component, the *"feed back."* The sender's interpretation or decoding of this response to his message would complete one round of the communication cycle. Normally, this first round is merely a preliminary to many other rounds, each adding something to what the sender and receiver already know about each other's position and hence about the possibility of some mutually satisfactory agreement. Such interactions may, of course, sharpen hostilities but they also form the basis of compromise.

The foregoing processes have been clearly evident in our recent affairs. How the Association said it feels about the educational preparation of the nurse, about legislation affecting nursing, and about its predictions for the future, has certainly resulted in a "feed back." As the sender of the initial message, the R.N.A.O. must decode this "feed back" and commence another round or rounds of communication with our various publics.

The message we *must* send out today is a clear, decisive and convincing statement on what we, as nurses, think nursing is. If we will do this, we will be able to define the types of practitioners necessary to provide nuring, the educational preparation required for each type, the necessary legislative controls which may be applied to all who nurse for remuneration, and the socio-economic status of each member. A more important outcome will be our ability to speak authoritatively and uniformly on nursing matters with the groups in society who are responsible for provision of health services.

This is the number one issue on a list confronting us. *It is past the stage of being an urgent issue, it is a crisis.*

Many of us will become greatly exercised over such issues as the influence of the College of Nurses on the R.N.A.O., or the categories of membership, or what the Association is purported to have said in its Brief to the Royal Commission on Health Services. It is right and proper that we should, and that we express ourselves on these matters, but I appeal to you to set your sights on the definition of nursing.

How do you feel about nursing? What do *you* think it is? Will *you* help nursing move steadily toward greater freedom to exercise judgment and to accept the consequences for its action? If nursing is to be a profession, then it must be responsible for its standards of education and service. Each one of us must understand the inherent implications and be able to communicate professionally.

A profession has a twofold function. It must provide what is immediately necessary, and simultaneously plan to provide for each member in the future the reality of achieving what it believes most desirable, and it must continue to enrich its service to mankind.

Nursing has been accorded the courtesy of a professional status by the public whom it serves. It is natural that we should find ourselves subjected to the varying influences of society and of such specific groups as the medical association, the hospital association, the hospital services commission, the Department of Health of the Government, and the public at large.

You will recall that these specific groups sat around an R.N.A.O. conference table in March 1960 and agreed upon the following principles as a basis for the development of new nursing legislation: The Nurses Act 1961-62.

1. A profession has the right to control its standards of education and practice.

2. The control of minimum standards is through a governing body composed of:

(a) representatives elected by every member of the profession residing in Ontario, these to comprise the voting majority;

(b) representatives from the organized profession;

(c) the appropriate cabinet minister.

Does each member of the R.N.A.O. recognize the significance of these principles when applied to nursing legislation? They mean that nurses and only nurses, with the exception of the Cabinet Minister, should be on the governing body. Why has there been strenuous activity on the part of a non-nursing association to have the Act opened to provide for its representation on the Council when it has been repeatedly stated and promised that the governing body would seek liaison with allied health groups?

As an association we have charged the members of a working party, and now the provisional council, to develop legislation and regulations in accord with these principles. Have we, as an association, done our share? Are we as members clear on the significance of these principles? Are we still united in our support of these principles? Has each one of us exercised our influence to interpret to our various publics and to our employers our professional conviction that the application of these principles will ultimately improve the quality of service to our patients? Have we communicated sufficiently to explain that nursing must be permitted to control its standards of education and practice and that it is not desire for power that has motivated nursing to assume this rightful responsibility?

The College of Nurses has indicated that it will seek liaison with all bodies who are concerned about nursing. Its responsibility, however, rests with the implementation of minimum standards.

In contrast, the R.N.A.O., as a professional organization with voluntary membership, concerns itself with trends and to advance standards. Each member is free to communicate her individual opinion to the Association and to the public. If there is agreement on principles and on policy within our Association, then we can individually and collectively exercise some powerful and far-reaching influence on opinion-making processes — but individually, we must communicate the same idea.

We have taken the first step toward defining our professional role when, through our influence, nursing legislation has been enacted which is based

on sound professional principles.

The second issue is the need to define and establish a system of nursing education. We have made statements that nursing education should come within the framework of a general system of education, that it has the right to expect public financial support and that a system should provide flexibility and freedom for experimentation. *It is the business of the professional organization to define such a system and influence its development.* Should such a system be a new department within the framework of government where, among other functions, it could receive and dispense public funds for the operation of schools preparing practitioners at the "still to be defined" levels? Should it be integrated within the Department of Education? Can we foresee some other type of structure such as the one recommended by the Canadian Nurses' Association in its Brief to the Royal Commission on Health Services — namely,

> That Advisory Committees on Health Services be established at regional and national levels to provide for cooperative and coordinated planning and that these committees include representation from the appropriate professions?

But is an advisory committee at the provincial level adequate for such a task, and more important still, whom would it advise?

If schools are to exist as schools, some method of financing and control must be found which will assure their function and freedom as educational institutions. Would it be worth some soul-searching study to determine if the machinery of the College of Nurses could be expanded to include the responsibility for handling public funds which would be clearly earmarked for financing nursing education?

Our schools are confused and the practice of nursing begs clarification. We may cry out for leadership, but no leadership can emerge unless there is an informed membership providing support. An informed membership means every nurse a member of the Association with a sense of personal responsibility about her profession. Reduced to a simple formula for action, it is clear that the issues must be defined and focussed and the group must communicate together.

My third point is possibly the most important question confronting us since its answer will determine the solution to the issues already outlined. *As an individual, is the nurse an effective communicator?* Where does she learn to communicate on nursing? That she begins in her first experience in nursing is probably a trite statement, but one would expect skill to be initiated in her basic preparation. If, however, we are to convince the public that a nurse must be something more than a skilled technician in meeting the nursing needs of society, we must introduce, expand and make a central focus of liberal education in the nursing curriculum. If her education is so broadened it will provide her with the intellectual vitality and stimulation so necessary for personal growth and ability to adapt to the expanding and complex tasks in the health program. It is imperative that a basic program provide a student with opportunities to learn and understand the entire life processes. In so doing, the nurse will be equipped to assume her larger share of responsibility in community life, and thus to communicate more effectively in order that the public will recognize her professional stature.

Henry W. Knepler, a professor of English, described the professional nurse's need for communicative skill, in part as follows:

> The professions are facing the fact that today's high school training in communications is not sufficiently thorough, and it comes at a point too early in a young person's life to fill the needs that will arise later. The professional person should be aware, to some extent, of the social and cultural implications of his work and his profession. He has to learn to think in broader terms — both of his specialized field and of other fields. The objectives of a course in communication in a school of nursing should be twofold:
>
> 1. It should equip a student to think more clearly, to express herself more concisely, to read with understanding and to write without error or ambiguity.
>
> 2. It should acquaint her with the forces that influence social and cultural patterns of the persons whom she will

serve as well as those with whom she will be associated in the health team and in the community at large.

It would appear that some courses in English are essential if nurses are to communicate successfully with members of the medical profession, her own colleagues, politicians who vote on health matters, allied professions, her employer, those who control the finances, and last but not least, with patients who come to her with a wide diversity of educational backgrounds. If we accept the premise that the individual nurse needs communicative skills, then we may fairly ask, with whom does she communicate and what does she communicate?

At the moment, we tend to be very concerned about the trend toward development of "professional" nurses and some other yet-to-be-defined category. Viewed from the level of the individual registered nurse in 1963, this trend becomes very personal and is fraught with considerable anxiety.

We see what we think we see and we hear what we think we hear. How do others know us for what we are? How do we communicate our way of life, our viewpoint, our reactions? The desire to express ourselves and gain recognition must be fulfilled. Language is the medium. To convey ideas we use words that describe, define and state precisely what we want our listener to know and think about. I will attempt to convey some ideas in this relationship, which, perhaps, will allay fears about the present or future status of registered nurses. Also, I hope that I may assist you in recognizing your role in any revision of the present status quo. Listen carefully since in an emotional situation, tone, not words, may provoke the response, and impatience, not semantics, may trigger a situation wherein communication may not achieve the desired effects.

Let us recall the function of a profession. It must do two things simultaneously, provide what is immediately necessary and plan realistically for the future.

What do we mean when we speak of the professional nurse of the future?

Wm. J. McGlothlin in writing about "The Place of Nursing Among the Professions" said:

My analysis of nursing as a profession makes me confident of the future. The professional school of nursing, strengthened and enhanced by its integration in the university, will be able to produce not only practitioners but philosophers, not only students but scholars, not only registered nurses but researchers. Furthermore, I am hopeful that graduates in nursing will undertake to strengthen their profession through strongly supporting efforts to increase its learning and thereby expand its responsibilities. Recent graduates have the opportunity to attack old problems with new zest. With vigor and determination they can advance the profession of nursing to new heights, as by precept and example, they shape their profession to glorify learning and knowledge and the discovery of truth for nursing's benefit and also the benefit of all mankind.

Is nursing a learned profession? Can nursing meet the criterion of a body of transmissible knowledge to which it constantly adds new knowledge through research? It has yet to produce its full complement of great scholars, or researchers, or philosophers. The future will bring more scholarship, more research and more learning into nursing. A profession matures as it moves from apprenticeship which is based on learning by imitation, through a separated professional school, where some study strictly within vocational concerns is combined with apprenticeship, into the professional school of the university. Only the latter combines the basic arts and skills of application into a sequence of learning with both breadth of scope and depth of understanding which exceed anything possible under the apprenticeship separate professional school, yet four-fifths of nurses are trained in hospital schools useful to the end of training nurse practitioners, but often cruelly limited in faculty time for scholarship and research and placed in an environment where the pressures of practice are often too great to allow time for study and reflection.

The above four-fifths includes the majority of us. When we become very emotional about the implied threat to our individual professional status, are we acting professionally? The mark of a professional person is being able to subjugate and sacrifice personal goals if necessary to satisfy the greater needs of the majority who constitute the pro-

fession or the persons whom it serves. We have been brought to the present crossroads in nursing by eighty years of nursing growth in Ontario. It is most unlikely that those who have spawned the need for and acceptance of nursing as a learned profession are going to be disqualified by the fearsome monster of the profession itself.

Can we expect to witness nursing being considered among the learned professions within the next eighty years or within the next twenty or the next ten? Have we kept pace with developments in science and other changes in our social structure?

We have been slow starters! We have two alternatives — to be left out of the race or to catch up. We must all try to understand and communicate about what is going on around and within us, if we are to stay in the race. As individuals, we cannot effect all the changes that are necessary or desirable. On the other hand, we can certainly effect change and take an active part by using fully the machinery of our association so that when it speaks, it can speak for nurses about nursing and so that its individual members understand what it is communicating.

What of the role of the association in the future? A profession must concern itself with standards beyond the minimum required by law to protect society. That is where the individual member has a responsible role to fulfill. It requires immense personal courage and integrity on the part of its members, before an association can discharge its responsibilities for the betterment of mankind. The individual member is responsible to and for her professional association as well as to her patient.

Let us refocus attention on the five components of communication. These are — first, an idea; second, an expression of the idea; third, interpretation; fourth, reaction; fifth, feedback and re-analysis. There are two critical issues confronting nursing. These issues have been interpreted and now there is need for action and reaction. This can only come about if the message has closely paralleled the dominating sense of values, motives and aspirations of the membership, and if the message stimulates action. The nature of the membership, its social position, its attitudes, interests, intelligence, level of information, educational status, etc., has a determining influence on what communications will be given attention; how they will be perceived and interpreted; and what effects they will have.

Search your conscience and ask yourselves if these are the most important issues. Knowledge of important issues has little or no meaning until you recognize its relevance and validity in the nursing crisis of 1963. The need to see relationships and apply knowledge requires a disciplined and creative approach.

How does the individual member communicate her point of view, since everyone can not easily express her ideas in a group, even though she is actually thinking as quickly and creatively as the more articulate participants? Indeed, the articulate participants may or may not be the most intelligent members of a group. Unless someone among the group communicates her thinking no group can think together. Once an exchange of ideas is commenced, the discussion comes alive as each individual is caught up in the pursuit or development of an idea.

Thousands of words have been spoken about nursing and written into the files of the Royal Commission on Health Services. Are the ideas expressed going to die before they have been interpreted and before reactions have occurred? If there are reactions, are these based on an understanding of the fundamental issues or is the reaction simply putting off until tomorrow to think about them since they create discomfort or seem far away in time and space, or are they dispelled from the individual's mind since an individual *thinks* there is nothing she can do about it anyway?

To communicate about nursing, the individual member needs to realize its functions in contemporary society and society's concept of those functions. Independently, a member can read and become informed about the changes taking place in her profession. In informal groups, in chapter and district meetings as well as in the provincial

meetings, she may participate and contribute to the thinking and interpret that thinking as she reports to her representatives.

Nursing is not dissimilar to other professional groups. There are the doers and the dreamers, the followers and the leaders. Leadership originates in a desire to learn from others and acquire as much perspective as possible on fundamental issues. Once a member has communicated her idea, she will be stimulated by the experience of contributing to further development of thought. In so doing, she should be prepared for healthy disagreement. Eventually, she must make up her mind and take a stand on an issue. This stand should not be based on the emotional tone engendered by interpersonal reactions. If her opinion turns out to be a minority one, this should not distress her. There is little to be gained by the individual or by her profession if she does not express her own ideas and react to the opinions of others. She has a real responsibility to communicate if she accepts membership since this is the very essence of membership.

What have *you* said during the past year? What do *you* think about what *you* have said? What ideas do *you* currently entertain about important nursing issues? What do you think *you* should say about these in the future? With whom should *you* communicate? Will *you* communicate?

M. BLANCHE DUNCANSON, B.SC.N.

WHY CITIZENSHIP DAY?

Citizenship Day is a peculiarly Canadian institution. It is not a public holiday. It is an annual observance, first proclaimed in 1950, as a day on which "suitable exercises could be observed, both in school and by public-spirited organizations, in order that we may become more deeply conscious of our own citizenship and all that it implies."

The emphasis on our citizenship was a natural consequence of the passage of the Canadian Citizenship Act which, in 1947, gave us a distinct Canadian citizenship. Previously, a Canadian had been entitled to the designation "Canadian national" or "British subject," and, when travelling abroad, he did so as a "British subject domiciled in Canada." By the new act, everyone born or naturalized in Canada, while remaining a British subject, had the status of Canadian citizen. Immigrants could become citizens after five years' residence in Canada, provided they met the other necessary requirements.

With the new interest in Canadian citizenship, many groups and organizations urged the Government to set aside a day on which the advantages and responsibilities of Canadian citizenship might be emphasized. It was further suggested that this day might be the same as that on which Empire Day was observed in the schools, that is, the last school day before Victoria Day. After consultation with the provincial Premiers, the Federal Government announced that the first Citizenship Day would be observed on May 23, 1950. For the next seven years, a special proclamation setting the date was made each year, but in 1958 the Government announced that henceforth Citizenship Day would fall on the Friday preceding Victoria Day. This holiday, on which the Queen's birthday is officially celebrated, occurs on the Monday preceding May 25.

It is now customary for many public bodies, school authorities and voluntary organizations across the country, to observe Citizenship Day by appropriate programs or ceremonies. On this occasion, Canadians of whatever origin or birthplace, may reflect together on the rights and duties, institutions and privileges which they share through common membership.

CNA's New Executive Director

JUNE FERGUSON

A leader, they say, is not one who achieves by his personal powers, but one who inspires all those under his command.

No one fits this description more aptly than the young woman named by president E. A. Electa MacLennan to administer the CNA's extensive program aimed at maintaining and improving the ethical and professional standards of nursing. DR. HELEN K. MUSSALLEM, who has been an inspiration to student and educator alike in the nursing profession, is one of Canada's most outstanding leaders in the field of nursing education.

The newly-appointed executive director of the Canadian Nurses' Association was a key figure in the CNA's pilot project on the evaluation of nursing schools in Canada, the two-year survey which took her from coast-to-coast and culminated in the two major projects presently being carried on in the association's national office (the school improvement program and a program for the evaluation of the quality of nursing service). She has more recently completed a study of nursing education in Canada for the Royal Commission on Health Services.

(Paul Horsdal Ltd., Ottawa)

HELEN MUSSALLEM

Dr. Mussallem took over the reins of office just three months ago on the retirement of M. Pearl Stiver. Though she has barely had time to get her feet firmly planted under the desk, she has given five major speeches in four provinces since her appointment. Next month will see her in Geneva meeting with the International Council of Nurses; then in Lausanne at the Red Cross International Study Centre. All this activity testifies to her belief that a profession and its professional associations must be unendingly engaged in pressing for higher standards for its practitioners.

As Dr. Mussallem explains it, "we as nurses and members of nurses' associations are committed to dissatisfaction with things as they are. We may never indulge in smugness which assumes that everything possible has already been attained. We are committed to the search for better ways of performing our tasks."

In her capacity as executive director of the association that speaks for nursing in Canada and abroad, Dr. Mussallem has an excellent opportunity to evolve the search for better ways.

To her CNA post she has brought a store of wide knowledge gained in nursing and the nursing education field. Born in Prince Rupert and educated in Haney, B.C., Helen Mussallem graduated from the Vancouver General Hospital, and, after study in administration and supervision at the University of Washington, she returned to the Vancouver General as operating room supervisor. Came the war and Helen Mussallem donned the uniform of a Canadian nursing sister, to spend four years overseas in the northwestern campaign. After her discharge from the Royal Canadian Army Medical Corps, she returned to her Alma Mater for ten years. It was in this period that she obtained her bachelor of nursing degree from McGill University and her master's degree from Teachers College, New York.

The former associate director of nuring at the VGH came to Ottawa in 1957 to undertake what she termed, "a rare privilege and unique opportunity to become involved in an exciting professional journey." Between 1957 and 1959 she logged 60,000 miles by all modes of transportation and interviewed some 2,000 Canadians to get the facts for her 138-page survey of nursing education. She spent the next three years implementing the recommendations in that study and obtaining her doctoral degree from Columbia University. It was in the latter part of 1962 that she was seconded to the Royal Commission on Health Services.

The way she manages to accomplish so much, and is always eager to accomplish more, is no mystery to Helen Mussallem herself. "Every day is precious: I want to put all I can into each one," she says. Those who know her well agree she is a woman to whom living is not only a hobby, but "a wonderful challenge."

This new post to which Dr. Mussallem has pledged herself offers her yet another challenge in meeting the nursing needs of this country. She believes that the future demands a clear, unequivocal design, consistent with the world in which we live, and that new goals in nursing should be predicated on a clear understanding of a Society's Health needs. These goals, she explains, should take cognizance of the various levels in nursing and be directed toward the probable future, not the certain past.

Her feelings about the nursing needs of Canada are perhaps best expressed in her recent address to the Manitoba Association of Registered Nurses, in which she said:

> Each person's efforts that contribute to the health and welfare of his fellow man are significant. But we must recognize that no longer can an individual work alone in the health team. The success of that team depends on every individual's fullest contribution to the goals of the team. There are no islands anymore, not even professional ones.

"However theoretical the content of nursing may become," Dr. Mussallem said, "it is always concerned with humanity and must inevitably focus on the life process of man and his universe. To add to the theoretical knowledge already accumulated, nursing will become more dependent on research and the focus of research should be on the improvement of nursing practice and how we may assist in aiding man to achieve a state of complete physical, mental and social well-being."

An automatic blood-loss measuring device, called Perdometer, has been designed by a Swedish engineer. This high-precision monitor will replace previous methods of weighing surgical towels, which have had the draw-back of also registering the volume of other body fluids.

— *The Swedish-International Press Bureau*

No man can justly censure or condemn another, because indeed no man truly knows another.

* * *

Happiness is as a butterfly, which, when pursued, is always beyond our grasp, but which, if you will sit down quietly, may alight upon you. — HAWTHORNE

Nursing Care Requirements for a Polio Unit

ESTHER PAULSON, NORAH MILLWARD and IRENE HARKNESS

Pearson Hospital, Vancouver, was opened in 1952 for tuberculosis patients. By 1955, an addition had been built for 50 post-polio patients. This change naturally presented a staffing problem. Would the same staff be adaptable to such varied clinical services? How much and what kind of nursing care would such patients require? How many staff members would be needed?

Nursing care standards for the tuberculosis service of the unit were worked out in a study started in 1950 and revised as necessary. Since there were apparently no staffing guides available for polio nursing, staffing was based on subjective opinions until this study was undertaken in 1960.

Objective

To obtain factual information as a basis for :

a. Assessing the amount and kind of nursing care for polio patients;

b. determining staff requirements in relation to fluctuating numbers and needs of patients.

Introduction

The project, its objective and its method, were explained to the entire staff. Pertinent points were outlined on a mimeographed form and given to all staff members. (See Form A.)

Method

Forms were prepared on which to record data related to nursing routine and procedures, treatments and medications.

Stage 1

All staff members recorded time spent on nursing care and procedures, treatments, and medications (nurses only).

Stage 2

Times for each shift were totalled and recorded. Total time for all staff on each shift was recorded on a 24-hour summary with separate records for male and female areas. (See Forms B, C, D.) A weekly summary was prepared from the 24-hour summaries. Table 1 shows the time spent by all groups on the various procedures.

Initial Staffing Changes

1. Findings from Form B were examined to assess whether some non-nursing activities could be reallocated. It was found that 47.3 hours were being spent on housekeeping duties. (See items indicated on Form B.) These duties were subsequently transferred to the housekeeping personnel.

2. Study of the comparative report of staff time provided and time accounted for showed excess staff time on the evening shift in both areas. (See Table 2.)

The staffing quotas were adjusted by removing a nurse from evening shift and adding one to the day shift. A nurse aide joined the evening shift.

Peak work periods were lightened by redistributing routine duties, for example children were bathed and the Hubbard tank was cleaned on the evening shift.

The results of the study were ap-

Miss Paulson is director of nursing of Pearson Hospital, Vancouver, B.C., Miss Millward is supervisor and Mrs. Harkness, head nurse, of the Polio Pavilion.

plied later in determining further staffing adjustments when admissions and turnover of patients increased. For example, nurses were reduced from 12 to 11 in number; nurse aides were increased from 15 to 17; orderlies were increased from 11 to 12 and augmented by casual help to provide 7-day coverage.

Stage 4

In order to have a definite basis on which to decide staff requirements it was necessary to determine the standard of nursing care hours needed per patient in a 24-hour period. Male and female patients were selected in three broad categories — minimal, regular and maximal care.

The patients were briefed to obtain their cooperation and thus ensure greater accuracy. They frequently reminded the staff to record the times. All items of nursing care were recorded in minutes for a 24-hour period for each category on a bath day and a non-bath day. The findings are compiled in Table 4.

Stage 5

The standard of nursing care hours was calculated for the three types of patients in a 24-hour period. (See Table 5.)

Until the results of the study were available, staffing on the polio unit had been based on subjective analysis. At this stage of the study, the staffing on the male side was greater than the time required. Having arrived at standard time units for patients in the three categories, it was then possible to assess staffing on a realistic basis at any given time. Forms were devised on which to prepare a monthly assessment of patients according to the three categories and other pertinent factors.

The monthly assessment provides the basis on which to determine the adequacy of staffing and whether or not changes are indicated due to new admissions and a fluctuating volume of care.

1. Patients are grouped categorically.
2. Time units are applied to determine the total amount of nursing care needed.
3. Findings are related to the staff time required.

Further Staffing Changes

Nurse aide quota was reduced from 17 to 16 by removing an aide from evening shift on the male side. (See Table 3.)

All stages of the study were reviewed, the findings compiled and applied to the present situation, for example :

1. Patients in residence were classified by category;
2. Amount of nursing care required in each area, based on the standard hours of nursing care for the three categories, was estimated;
3. Comparison of staffing in male and female areas was carried out to determine any disproportionate distribution of staff, and/or volume of work.

Requirements and Staffing Cumulative Totals

of time needed and provided
for one week

Male

A.M. needed 332 hr. 27. min.
provided 368 hr.
P.M. needed 169 hr. 25 min.
provided 343 hr.

Female

A.M. needed 437 hr. 32 min.
provided 342 hr. 30 min.
P.M. needed 298 hr. 29 min.
provided 267 hr.

1. Night shift is not included because coverage in excess of actual nursing care hours required must be maintained for safety reasons.
2. Time provided on day shift does not include that given by the head nurse, assistant head nurse or maintenance orderly. However, their help does offset the difference between time needed and time provided on the female area.
3. Final figures show more time provided on the male side on day and evening shift. One reason for the low volume of work in the latter period is due to the male patients' preference for being transferred to their tank respirators at the end of the day shift while female patients prefer to wait until bed time. It is necessary to provide excess time on the evening shift for safety reasons to cope with peak periods of work, unexpected staff absence and other emergencies. However, need for adjustments were indicated to divert some of the excess staff hours from the male area to the female area. This was done by assigning an assistant from the male area to do the bedside care for the children

TABLE 1

Forms of Care

MALE AREA

16 Patients + 1 admission on last day of study

	A.M.	P.M.	Night	1 week all shifts
Nursing routines and procedures	17,801	11,573	2,092	31,466
Treatments	1,779	828	219	2,826
Medications	256	495	70	821
Maintenance Orderly	480	—	—	480
Totals: Minutes	20,316	12,896	2,381	35,593
Hours	338.6	214.9	39.7	593.2

FEMALE AREA

14 Patients — 1 discharged on last day of study

	A.M.	P.M.	Night	1 week all shifts
Nursing routines and procedures	13,644	7,603	3,813	25,060
Treatments	938	415	227	1,580
Medications	212	205	91	508
Maintenance Orderly	210	—	—	210
Totals: Minutes	15,004	8,223	4,131	27,358
Hours	250	137	68.8	455.9

Stage 3

Staff hours provided in relation to time accounted for were compiled in a comparative report. (See Table 2.) Staff hours provided by different groups — nurses, nurse aides and orderlies — were tabulated. (See Table 3.)

TABLE 2

MALE AREA			*FEMALE AREA*		
Staff hours provided		*Time accounted for*	*Staff hours provided*		*Time accounted for*
A.M.	376 hours	338 hours	A.M.	258 hours	250 hours
P.M.	262 hours	215 hours	P.M.	184 hours	137 hours
Night	105 hours	40 hours	Night	105 hours	69 hours

and to move the tank respirators and beds between the ward and storage area. Even with this change the division of time was not equalized sufficiently. Consideration was given to further changes, the main one being to transfer the children to the male area so that all care, regular and incidental, would be given by that staff.

The changes occasioned by the study were accepted by staff and patients and resulted in a trend toward greater flexibility in the use of staff for the department as a whole, rather than for the separate areas. Similar changes might have been arrived at by the trial and error approach. The study provided specific data and factual information. As a result, the explana-

tion for necessary changes to improve the situation was simplified and made more convincing to administrative officials and staff members alike.

Form A

Time Study

This is the first time that a time study has been carried out on polio nursing in British Columbia. Staffing has been based on estimated rather than definite figures as to the amount of nursing time required.

Conditions on the ward are different than they were when the ward was opened in April, 1955, for example:

1. Fewer patients;

TABLE 3

MALE AREA

	A.M.	P.M.	Night	All shifts—1 week
11 Nurses	60.5	52.5	52.5	165.5 hours
17 Aides	97.5	52.5	—	150 hours
12 Orderlies	210	157.5	52.5	420 hours
Other	8	—	—	8 hours
Total hours:	376	262.5	105	743.5 hours
Nursing care accounted for				593.2 hours
Difference				150.3 hours

FEMALE AREA

	A.M.	P.M.	Night	All shifts—1 week
11 Nurses	75	79	52.5	206.5 hours
17 Aides	180	105	52.5	337.5 hours
Other	—	—	—	— —
12 Orderlies	3.5	—	—	3.5 hours
Total hours:	258.5	184	105	547.5 hours
Nursing care accounted for				455.9 hours
Difference				91.6 hours

TABLE 4

MALE PATIENTS					*FEMALE PATIENTS*			
A.M.		*P.M.*	*Night*		*A.M.*	*P.M.*		*Night*
Bath	*Non-Bath*				*Bath*	*Non-Bath*		
128	112	68	41	Minimal	161	136	126	28
163	158	71	34	Regular	247	189	133	50
185	186	116	55	Maximal	270	276	146	24

TABLE 5

MALE STANDARDS		*FEMALE STANDARDS*
3.8 hours — 3 Patients	Minimal	5.9 hours — 5 Patients
4.4 hours — 11 Patients	Regular	6.5 hours — 9 Patients
6.0 hours — 4 Patients	Maximal	7.4 hours — 5 Patients

The above standards show a variation in nursing care time required by male and female patients. Female patients require longer time for most routine care than the male patients. Personal grooming, so important in maintaining morale, is time-consuming.

2. a staff familiar with this type of nursing has been built up;

3. the routine of the ward had been stabilized;

4. the amount and kind of nursing care and types of patients change from time to time; staff numbers have to be arranged accordingly.

This last point is the main reason why it is important to have definite facts on which to base nursing care requirements of various types of patients in order to know how many staff members are needed to give that care.

Similar studies have been carried out for tuberculosis nursing through the years and the same method and type of record can be applied to the polio nursing time study. Two records — one for treatments, the other for routines and procedures — have been prepared. The interest and cooperation of every staff member is important and essential as the recorded information must be accurate and complete to be of value.

FORM B

* Housekeeping duties that might be transferred to Ward Assistant — 47.3 hrs. per week.

Comparative Summary of Findings

All Groups

24-hr. summary in minutes Nursing Routines and Procedures	*MALE* A.M.	P.M.	Night	Total	*FEMALE* A.M.	P.M.	Night	Total
Organization & Planning								
Planning assignments, directions to team members. Observing duties of team members; follow-up demonstrations	85	70	—	155	147	20	10	177
Patient conferences	174	468	20	662	130	46	25	201
Staff conferences	393	261	115	769	295	350	140	785
Housekeeping supervision — e.g. linen, general ward cleanliness, ward assistant supervision	6	—	15	21	32	—	—	32
Clerical								
Recording and utilization of: Charts, Kardex, nursing care plan	136	75	270	481	127	32	478	637
Writing reports	130	135	105	370	115	95	65	275
Requisitioning daily supplies	43	—	—	43	36	—	—	36
Daily checking of supplies from S.S.R.	38	—	—	38	26	—	—	26
Ordering and checking pharmacy supplies								
Daily narcotic count	59	38	153	250	43	24	150	217
Nursing Care—Physical Basic								
A.M. care, washing, dental and back care	2415	138	96	2649	1581	—	525	2106
P.M. care, applying makeup	—	—	—	—	333	125	—	458
Aural and nasal care	77	18	—	95	81	15	—	96
Nails and hairdressing	233	15	—	248	385	41	10	436
Bedtime care, dental, face washing, back care, positioning	90	3869	294	4253	38	3325	542	3905
Baths: on rocking bed. Tub: on stretcher to and from bathing room	764	65	—	829	1170	—	—	1170
Weights	18	—	—	18	17	—	—	17
Bedmaking: respirators and rocking beds	1629	8	—	1637	1070	15	87	1172
Temperatures (daily)	121	5	—	126	185	3	—	188
Blood pressures	57	58	—	115	50	—	—	50
Shampoos	30	—	—	30	140	—	—	140
Bedpan service	1844	175	130	2149	1916	1014	466	3396

FORM B

(cont'd)

24-hr. summary in minutes Nursing Routines and Procedures	MALE A.M.	P.M.	Night	Total	FEMALE A.M.	P.M.	Night	Total
Dietary Service								
Preparation of patients, tray distribution, feeding, extra nourishment and fluids	3079	2238	558	5875	2166	1391	367	3924
Nursing Care—Miscellaneous								
Moving patients: Respirator to rocking bed, rocking bed to wheelchair	1456	1289	154	2899	819	31	510	1360
Ice water distribution at 6 P.M.	—	155	—	155	—	100	—	100
Accompanying and remaining with patients at special clinics	160	—	—	160	—	34	—	34
Preparation of patient for leave of absence — e.g. equipment, medications, supplies	242	30	—	272	35	—	—	35
Making of hot drinks at 8 P.M.	—	320	—	320	—	170	—	170
Preparation of patients and ward for entertainments: e.g. shows, concerts	—	55	—	55	—	85	—	85
Nursing Duties. Cleaning & Sterilizing								
*Bedpans, urinals and baby linen	521	170	—	691	391	123	124	638
Thermometers	32	2	—	34	36	36	—	36
*Medicine glasses, crockery	70	170	—	240	23	190	—	213
Dressing wagon	23	—	—	23	14	—	—	14
Collection and distribution of supplies	304	37	—	341	359	15	50	424
Teflon and polyethylene tubes	45	—	—	45	60	22	5	87
Silver tracheotomy tubes	25	—	—	25	5	—	—	5
Changing suction trays, bottle and tubing	10	—	57	67	—	—	16	16
*Wheel chair cleaning	140	65	—	205	—	—	—	—
Personal Service to Patients								
Dressing patients	1160	45	—	1205	787	—	202	989
Page turning (books and magazines)	629	623	60	1312	348	136	25	509
TV and radio adjusting	236	412	60	708	99	80	1	180
Canteen	65	8	—	73	5	—	—	5
Library	—	60	—	60	6	10	—	16
Telephone (portable)	238	313	—	551	30	81	—	111
Letters—opening, holding, adjusting on reading rack	319	69	—	388	121	—	—	121
Letter writing	110	35	—	145	22	—	—	22
Hair setting	2	17	—	19	139	30	—	169
Shaves	341	57	—	398	—	—	—	—
Housekeeping								
*Extra cleaning of bed units: Bedsprings, lockers, bedside tables	170	—	—	170	242	—	5	247
*Cleaning utility rooms	82	5	5	92	20	—	10	30
TOTAL	17801	11573	2092	31466	13644	7603	3813	25060

FORM C

Treatments

	MALE				*FEMALE*			
	A.M.	P.M.	Night	Total	A.M.	P.M.	Night	Total
Enemata: Soap and water, Fleet	65	—	—	65	48	—	—	48
Suppositories: Glycerine, etc.	196	10	—	206	29	—	—	29
Catheterization	—	—	—	—	30	—	—	30
Douche	—	—	—	—	35	—	—	35
Oxygen: Tent, aerosol, Nebuliser	10	15	—	25	—	—	—	—
Inhalations	70	10	—	80	—	—	—	—
Dressings: Sterile, tracheotomy, infected toes	224	50	—	274	120	10	—	130
Medicinal drops	9	30	29	68	5	2	2	9
Tanking	155	—	—	155	155	—	—	155
Application of portable respirators	443	171	40	654	257	83	155	495
Suctioning	330	238	76	644	68	61	—	129
Obtaining laboratory specimens	—	5	2	7	15	—	30	45
Measuring intake and output	147	255	72	474	6	6	13	25
Urine tests: Clinitest, reaction	5	20	—	25	—	—	—	—
Application of special applicances	50	—	—	50	142	30	27	199
Miscellaneous: special shampoo, application of ointments, etc.	75	24	—	99	28	221	—	249
Postural drainage	—	—	—	—	2	—	—	2
TOTAL	1779	828	219	2826	940	413	227	1580

FORM D

Medications

MALE

Injectable

A.M.		P.M.		NIGHT		TOTAL	
No. given	Time req'd	No. given	Time req'd	No. given	Time req'd	No. given	Time req'd
4	16	6	18	5	22	15	56
8	23	6	60	5	30	19	113
5	20	6	60	5	28	16	108
7	22	5	50	6	28	18	100
4	12	5	60	6	22	15	94
5	15	6	60	6	28	17	103
5	15	6	60	6	30	17	105
38	123	40	368	39	188	117	679

Oral

39	31	49	35	3	10	91	76
39	40	59	90	11	10	109	140
51	25	59	70	11	10	121	105
67	45	59	80	14	10	140	135
39	45	59	70	16	10	114	125
39	30	59	80	14	10	112	120
48	40	59	70	15	10	122	120
322	256	403	495	84	70	809	821

FORM D
(cont'd)

Medications

FEMALE

No injectable medications given

Oral

A.M.		P.M.		NIGHT		TOTAL	
No. given	Time req'd	No. given	Time req'd	No. given	Time req'd	No. given	Time req'd
30	37	23	22	16	15	69	74
17	35	23	37	12	10	52	82
26	26	23	22	15	15	64	63
9	20	23	22	14	17	46	59
18	27	25	30	15	10	58	67
18	37	23	22	18	14	59	73
18	30	33	50	15	10	66	90
136	212	173	205	105	91	414	508

Esophageal Stricture

JOAN MORRELL

Pessimism was the reaction to this condition and the recommended surgery; optimism was the outlook for the future after the operation.

Betty Smith's problem began early in life. At two years of age she swallowed a small amount of lye while her mother was out of the room, and since that time she has had increasing difficulty swallowing solid foods. Now, at 21 years, she has been admitted to hospital complaining of severe dysphagia, anorexia and weight loss. X-ray reveals multiple strictures in the esophagus due to contraction of scar tissue. Surgical intervention is deemed necessary to provide a by-pass around the affected area.

Miss Smith is a very independent young lady. She left home at the age of 17, and came to the city where she secured employment as a waitress in a large restaurant. Several months later, she became a domestic and has remained in this position for the last three years. She is a quiet, nervous, rather introverted person who does not mix well with the other patients in the four-bed ward. She enjoys watching television and working at cross-word puzzles — activities that do not involve other people.

Preoperative Care

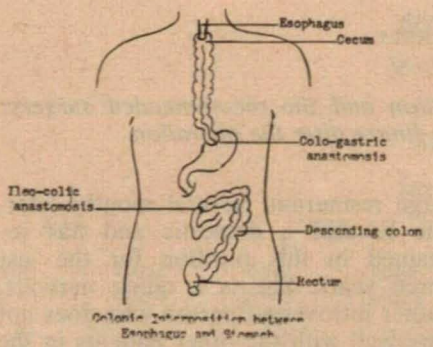
Although Miss Smith gave her written consent to the operation, she did not really accept it mentally. In fact, she was very apprehensive and pessimistic about the outcome. The surgeons, anesthetist and nurses spent much time with her — explaining, encouraging, listening, and, generally, providing support and understanding.

Miss Morrell was a third-year student at St. Joseph's Hospital, Saint John, N.B., when she prepared this study.

The patient's parents were notified of the impending surgery and offered to pay for private duty nurses. Their daughter refused this help, preferring to retain her independence. Since the surgeons agreed that she would need this extra attention following surgery, the head nurse made arrangements for private duty nurses to be available for the afternoon and night shifts.

An attempt was made to build up the patient's physical strength. Fluids, high in protein and calories were given along with semi-solid foods such as custards, poached eggs, etc. Vitamins were given intravenously.

It was essential that Miss Smith understand what would be required of her following the surgery. The physician explained that she would find herself in an oxygen tent, and that she would receive her nourishment intravenously for the first few days. Her nurse taught her deep breathing exercises and emphasized that she would be helped to sit up and turn in bed frequently. She was assured that medication would be given to ease her pain.



Two weeks following admission, the patient was prepared for surgery and taken to the operating room. Despite all the encouragement she had received, she was still very apprehensive, nervous and pessimistic about the outcome.

The surgical team consisted of two surgeons, two interns, an anesthetist and four scrub nurses. The operation — colonic interposition between the esophagus and stomach — was complicated and lasted over eight hours. It consisted of taking a portion of the right colon and anastomosing one end to the upper portion of the esophagus above the strictures and the other end to the stomach. This was followed by an ileo-colic anastomosis. The contents of the ileum would thus pass directly into the transverse colon. A temporary gastrostomy was then made and a retention catheter was brought out through a stab wound in the abdomen. The patient withstood the operative procedures well.

Postoperative Care

Miss Smith was placed in an oxygen tent to facilitate breathing. Blood transfusions and intravenous infusions were given by means of an intravenous cut-down. The catheter from the stomach was connected to a Wangensteen suction apparatus. Blood pressure, pulse and respirations were checked frequently during the first 48-hour period; the patient was watched closely for any sign of hemorrhage.

Mouth care was given hourly since the patient received nothing by mouth until the third postoperative day. At this time, the intravenous cut-down was removed and she was allowed to take sips of water by mouth every hour. Later the same day, she received one ounce of milk alternated with one ounce of water hourly through the gastrostomy tube. The nurse made certain that the patient had her feedings in privacy, by pulling the screens each time. She encouraged Miss Smith to lie flat during and after the gastrostomy feeding period so that there would be minimal leakage from the tube.

Nine days following the surgery, the patient complained of severe abdominal pain in the operative area. Her temperature rose to 103°F. X-rays and a blood culture, taken to determine the cause, were negative. Intravenous infusion and antibiotics in large doses were ordered and administered. Gastric suction was resumed and seemed to relieve the pain. Within a few hours Miss Smith felt much better. The pain was attributed to gas pressure aggravated by apprehension.

From this time on, Miss Smith's convalescence was incident free. Gradually her diet was increased from clear fluids and Sustagen orally to jello, ice cream, and then puréed foods. She was then allowed a very soft diet. The gastrostomy tube was removed and she finally began to realize that the surgery had been successful and that she would

have a chance to lead a normal life. Low-fibre, mild-flavored, nonstimulating and nonirritating foods were introduced, with a gradual return to a regular diet.

Thirty-five days after the operation, she was discharged to her mother's care. She was seen shopping four weeks later and appeared happy and carefree. She has gained weight and appears to have changed much in her outlook on life as well as in her appearance. A truly happy ending to what could have been a tragic story.

LEARNING TO LIVE WITH AN ULCER

SOLANGE AUDY

A discussion of the treatment and care given to a patient who had a bleeding ulcer.

Mr. L'Heureux, 45 years of age, was admitted to hospital with a provisional diagnosis of bleeding duodenal ulcer.

Prior to admission, the patient had been active in his various roles as electrician, father of four children, and respected member of the community. His outgoing personality and interest in others was evident during his hospitalization. He conversed freely with other patients, encouraging them to talk about themselves and their families. Thus he helped to create a happy atmosphere in the hospital ward.

Reaction to Illness

Mr. L'Heureux had confidence in those caring for him. He was willing to submit himself to any treatment that was deemed necessary. His stay in hospital was made more pleasant by frequent visits from his family and friends as well as by numerous cards and letters that he received. What especially pleased him was that his wife and daughter frequently brought him samples of home-cooked food. This thoughtfulness and consideration helped to keep him in high spirits.

Physical History

The patient first sought medical advice after he had a sudden bout of black-colored emesis followed by the passing of a tarry stool. He had not felt weak or dizzy after vomiting; rather, he had experienced considerable relief. He did not delay in consulting his physician.

On admission to the emergency unit, he appeared pale and rather anxious. The vital signs were normal and did not reveal evidence of shock. There had been no previous symptoms of an existing ulcer.

Tests and Examinations

Mr. L'Heureux was admitted to a four-bed ward. The head nurse introduced him to the nurse who would be caring for him, and to the other patients in the room. After he was comfortably settled in bed, his nurse explained hospital policies regarding visiting hours, meal-times, etc.

Various tests and examinations were ordered. Each was explained to the patient before it was carried out so that he would be less apprehensive.

The normal laboratory values for the tests as compared to those of the patient are shown:

X-rays of stomach and duodenum

Mr. L'Heureux was taken to the X-ray department for gastro-intestinal series consisting of several pictures of the stomach and intestinal tract, (following the ingestion of barium, a ra-

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Miss Audy was a junior student in the Edmonton General Hospital School of Nursing, when she wrote this article.

Urinalysis	Normal	Mr. L'Heureux
Specific Gravity	1.015-1.020	1.020
Color	pale straw to amber	yellow
pH	4.8-7.5	4.3
RBC	negative	negative
Hematology		
Red Blood Cell Count	4,500,000 to 5,000,000 per cu.mm. of blood	2,600,000 per cu.mm. of blood
White Blood Cell Count	5-9,000 per cu.mm. of blood	4,800 per cu.mm. of blood
Hemoglobin	14-18 gm./100 cc. for adult males	7.4 gm./100 c.c. on admission 12.8 gm./100 c.c. on discharge
Hematocrit	42-50%	22% on admission

diopaque substance). These are taken to detect any tumors or ulcerations of these organs.

The report revealed a small posterior ulcer in the duodenum.

Treatment

When a patient is admitted with a diagnosis of bleeding ulcer, a feeding program is promptly instituted if he is not vomiting. Mr. L'Heureux was given a full gastric diet in the form of purées, supplemented by feedings of milk and cream.

A gastric diet must be bland — that is mechanically, chemically and thermally non-irritating to the stomach mucosa. The foods must neutralize and inhibit acidity. For this reason, proteins and fats make up the major part of the diet. The proteins combine with the acid thus reducing the acidity. Certain easily digested fats, such as cream, butter and egg yolk, decrease the secretion of acid. Feedings of a milk and cream mixture are, therefore, effective in reducing stomach acidity. It is also important that the patient eats frequently, ingesting small quantities of food at a time.

The adjustment to this diet was not too difficult for Mr. L'Heureux since the restrictions were not severe. In a few days whole food was substituted for the purée. The dietitian explained it was necessary for him to avoid all fried, highly seasoned foods, raw vegetables and raw fruits (except for ripe bananas and orange juice) and alcoholic beverages because of their irritant capabilities. He was willing to adhere to these dietary restrictions since he realized their importance in promoting ulcer healing and in preventing pain and further bleeding.

Sedation of the patient is another important aspect of therapy. Mr. L'Heureux's physician ordered phenobarbital grs. ss t.i.d. to provide relaxation and rest.

Included in the treatment of a patient with bleeding ulcer, is the administration of whole blood. Mr. L'Heureux received a total of 2,500 cc's of blood during his stay in hospital.

Nursing Care

One important objective of the nursing care for any patient with an ulcer is to provide an atmosphere conducive to rest and relaxation. In caring for Mr. L'Heureux, the nurse organized her work so that she did not appear rushed. She allowed herself time to visit with him and to listen to his problems. Mr. L'Heureux found his nurse's backrubs relaxing and was often able to sleep in the afternoon following this massage. Treatments and medications were given at approximately the same time each day so that a regular, smooth routine could be established. All of these measures helped to ease his apprehension and to make him more relaxed.

Nursing care is never complete for any patient unless the spiritual aspect

of care has been considered. Mr. L'Heureux is a member of the Roman Catholic Church and his philosophy of life is strongly influenced by this faith. During his stay in hospital he was visited frequently by the parish priest. He enjoyed these visits and derived support from them.

Rehabilitation is another important nursing care objective. Actually, nursing shares this objective with other members of the health team. Rehabilitation begins at the time of the patient's admission to hospital and ends only when he has readjusted to his life outside. Mr. L'Heureux had already accepted the restrictions regarding his diet. He understood that physical and mental rest were of utmost importance to his well-being, and that adequate, moderate exercise was beneficial. The family was included in this planning since they would play an important role in the total recovery.

Mr. L'Heureux was discharged with the understanding that he would remain under medical supervision for at least a year.

Regional Ileitis

PHYLLIS LAPICKI

A challenge exists when a patient's progress depends on her own acceptance of a disease that stubbornly refuses to respond to treatment.

Mrs. Tansky has "regional ileitis" — often referred to as "regional enteritis" or "Crohn's disease," — a debilitating disease of unknown etiology. Her present stay in hospital marks her fourth admission in a two-year period.

Born in Poland 38 years ago, the patient immigrated to Western Canada at the age of four. She married when in her teens, and is now a grandmother as well as a mother. Following her marriage, she obtained employment in a laundry where she worked until forced to leave because of her present illness.

The patient states that she is quite emotional and frequently loses her temper. With these outbursts she experiences a mild tremor of the hands and arms which subsides with her anger. In hospital she appears quiet, occasionally rather moody, but never unpleasant. She has depth to her personality as revealed in our frequent discussions concerning life, illness, etc.

MEDICAL HISTORY

Mrs. Tansky was first admitted to hospital for investigation of possible bowel obstruction. She complained of increasingly severe midabdominal cramps, diarrhea, and weight loss. Bowel movements had become more frequent — about seven daily — and occurred shortly after each meal. The stool frequently contained undigested food, mucus and pus. An exploratory laparotomy was performed revealing constriction and thickening of the wall of the terminal ileum a characteristic finding in regional ileitis. At this time, the small intestine was anastomosed to the transverse colon in order to by-pass the diseased portion of the intestine.

Three months following this surgery, the patient was re-admitted, complaining of severe pain in the left rectal area upon defecation, persistence of frequent loose bowel movements, and weight loss. Examination revealed the presence of an anal abscess and an anal fistula. A fistulotomy was performed, and the abscess incised to promote drainage. A month later, she had an ileocolostomy with further resection of the diseased ileum. Another fistulotomy was required for recurrence of another anal fistula the following month.

Mrs. Tansky's present hospitalization — less than a year following her

Miss Lapicki was a junior student in the Misericordia Hospital School of Nursing, Edmonton, Alberta, when she prepared this study.

last admission — results from an exacerbation of her previous symptoms: crampy pain, frequent loose bowel movements, anorexia and weight loss.

NURSING CARE

Fecal material drains almost continuously from the patient's colostomy, causing the surrounding skin to become irritated and inflamed. The area is kept as clean as possible and dressings are changed frequently. This helps to eliminate odor and to prevent further irritation. Barriere-HC, a preparation of hydrocortisone alcohol in a silicone cream base, is applied topically to the area and helps to reduce the inflammation. Hot foments are also applied twice daily for an hour at a time. Although this moist heat is effective in reducing the inflammation, it tends to stimulate peristalsis, thus increasing the patient's abdominal discomfort.

The nurse's attitude to a colostomy will influence the patient's acceptance of it. With support, Mrs. Tansky had adjusted quite well to her colostomy during her previous period of hospitalization. She is discouraged now, however, because of its constant draining. Empathy and encouragement are an important part of the nursing care needed.

Various analgesics are given to Mrs. Tansky to help relieve her crampy abdominal pain. One nursing care responsibility is to make certain that she receives the narcotic as ordered, yet at the same time attempt to avert addiction. It has been found that Mrs. Tansky requires less medication for pain when she is relaxed and engaged in conversation with the nurse.

Due to the large amount of fluid being lost through drainage, dehydration is a continuing problem. To combat this, high-protein, high-caloric fluids are provided at regular intervals b e t w e e n meals. Encouragement is needed to swallow so much fluids.

Anorexia is another challenge that faces the nurse. At the beginning of her present admission to hospital, Mrs. Tansky refused to eat solid foods since they nauseated her, and caused the cramps and diarrhea to increase in severity. The dietitian visited her and planned special meals, catering, as far as possible, to her likes and dislikes. The results were most rewarding. The patient's tray is now taken away emptied of food. The diet — low residue, high-protein, high-caloric with vitamin supplements — is slowly having the desired therapeutic effect.

Mrs. Tansky's activity is limited. She has bathroom privileges and is allowed to sit in a bedside chair for a few minutes each day. Constant attention is thus necessary to prevent decubiti from occurring. Back massages are given frequently with extra care to bony prominences. Foot soaks are provided only occasionally since the patient's feet are very dry and scaly. Skin oil is rubbed on them daily and this helps to promote better peripheral circulation as well as relieving the dryness.

SUMMARY

Mrs. Tansky's signs and symptoms present the typical picture of advanced regional ileitis; midabdominal cramps with frequent, loose stools; anorexia and weight loss; obstructive symptoms; fistulae and abscess formation.

The etiology of this nonspecific inflammatory disease that affects the lower ileum is unknown. It is known, however, that little can be done to permanently arrest the process. Mrs. Tansky realizes that she has not been cured. She is aware that a dietary regime must be followed and that rest and avoidance of stress are imperative.

Frequent recurrence of acute attacks have left her somewhat discouraged. She is pleased, however, that she will soon be able to return to her husband and son who have provided her with so much support during the trying years.

A diplomat is a man who always remembers a woman's birthday but never remembers her age. — ROBERT FROST

It is with a word as with an arrow — once let it loose and it does not return. — ABD-EL-KADER

Acute Gallbladder Colic

M. HEINRICH

The pain of biliary colic can be the most excruciating ever to be experienced.

Mrs. White, 65 years old and mother of 12 children, had suffered from attacks of sharp pain in the right upper quadrant accompanied by nausea and vomiting for over 25 years. Frequently, following a meal with a high fat content, she had a feeling of fullness; a burning sensation in the epigastric region and a tendency to regurgitate small quantities of bitter, curdled gastric contents. Milk of magnesia or Epsom salts afforded some relief.

Eventually the pain of her attacks forced Mrs. White to consult a doctor who advised her to have an operation. Appalled by this prospect, she was only too glad to turn to the counsel of a friend who suggested that drinking water in which freshly peeled potatoes had been soaked was the answer to the problem. As a result medical treatment was deferred for two or three more years. Finally an acute attack of colic convinced Mrs. White to return to the doctor once again. This time she showed evidence of jaundice in the sclera.

She was admitted for diagnostic investigation and the subsequent results led to a diagnosis of cholecystitis and cholelithiasis. At operation she was found to have "an acutely inflamed gallbladder, full of stones both large and small, completely obstructing the cystic duct."

A definite reason for the formation of stones in the gallbladder and hepatic duct has yet to be found. There appears to be some connection between variations in the normal functioning of the liver and the biliary system and stone formation. The condition accompanies pregnancy so frequently that it has come to be accepted as one of the diseases of childbearing. Studies made over the past 50 years indicate that in the 35-55 age group, the occurrence of gallstones in women who have not been pregnant approximately equals the frequency with which men are affected. Incidence increases with increasing age. It has been estimated that one out of every three persons reaching 75 years of age will have gallstones.

Obesity has some bearing — possibly as a result of bile stasis — and some authorities feel that ascending infection combined with stasis is a factor. In proof, they note the frequency with which bacteria are recovered from operative patients and the wide variety of organisms involved.

The patient with chronic cholecystitis usually recounts a long-standing history of discomfort after eating — particularly if rich or fatty foods have formed part of the meal. This discomfort may include pain, nausea and vomiting. Quite often throughout early adult life the symptoms are sufficiently mild for the patient to ignore them. She learns to control distress by avoidance of overeating and by gradually eliminating from her diet foods that she considers to be the source of difficulty. Unfortunately, however, changes are proceeding: The number and size of the gallstones increase; the gallbladder wall becomes more scarred and the organ functions less efficiently; damage to the liver occurs. The end result may be that when the patient eventually seeks help from her doctor, possibly driven to it by an attack of biliary colic, she may be a poor surgical risk.

The pain of biliary colic is usually excruciating and occurs suddenly. It may begin in the epigastric region or at the right costal margin. Depending on the severity of the attack, the patient will have referred pain of varying intensity extending into her back and up into the right scapula. In some

Miss Heinrich is a student at Regina Grey Nuns' Hospital, Sask.

instances the pain may resemble that of cardiac disease so closely that differentiation may be extremely difficult. Colic can also occur without the presence of gallstones. Slight jaundice may be present if the stone is in the cystic duct, as a result of injury to the duct. Jaundice is much more marked if the obstruction is in the common bile duct.

Preoperatively, Mrs. White underwent a series of diagnostic tests including serum bilirubin estimation to check liver function and a cholecystogram using Telepaque — an opaque dye. Her gallbladder could not be identified on X-ray indicating poor function. An alkaline phosphatase test showed an increase, proof of blockage of the biliary tract. The diagnosis based on these findings was cholecystitis and cholelithiasis.

Mrs. White received the usual physical preparation for surgery — an enema, skin care, restricted oral intake, and rest. Her doctor and nurses made a point of explaining what had made operation necessary and outlined her care in general terms. In particular, at that point, they stressed that she would wake up in the recovery room rather than her own room and they emphasized the role of this department in her care. Her faith in the eventual outcome of her surgery and in the ability of those caring for her was so complete that Mrs. White declined a preoperative bedtime sedative and slept soundly.

Her operation under sodium pentothal and nitrous oxide anesthesia went well. Since she was discovered to have a cystic left ovary, oophorectomy was combined with cholecystectomy.

Nursing Care

The care of the patient with cholecystectomy involves control of nausea and vomiting; attention to respiratory function; checking vital signs, amount and type of drainage; prevention of circulatory complications; elimination and diet. The patient is naturally reluctant to breathe deeply since the high incision makes normal respiration painful. However, prevention of pulmonary complications is strongly dependent upon good lung function and frequent change of position. The patient should be instructed prior to operation in the art of deep breathing following surgery. It is extremely important that she understand its importance to her recovery.

Insertion of a gastric suction tube controls the discomfort and strain of nausea and vomiting. It must be remembered, however, that electrolyte balance will be affected as well and, for that reason, suction must not be prolonged beyond the stage of actual necessity. Intravenous therapy will be necessary for a few days to supply body fluid and nourishment until adequate oral intake is restored.

The nurse must know what type of drainage to expect from the wound; what drainage tubes are present and the care required. She must keep in mind that hemorrhage is a possibility, especially if the gallbladder was adherent to the liver and removed with difficulty. A drop in blood pressure, an increase in pulse rate should indicate to the nurse that her patient needs immediate attention. This emphasizes the importance of frequent checking of vital signs postoperatively.

Nurses generally are aware of the importance of exercise and early ambulation to thwart the shocking results of a patient's sudden collapse from embolism or the development of other circulatory ailments. Again, the patient needs instruction since, understandably, she may feel that the measures taken are unnecessarily stringent.

Mrs. White reached the recovery room in good postoperative condition. An airway prevented respiratory distress until consciousness was regained. In addition, her head was turned to one side and she was suctioned periodically to prevent aspiration of mucus or vomitus. Her gastric suction tube was connected and an injection of Gravol administered to control nausea and vomiting.

Pulse, respiration and blood pressure readings were checked q.15 minutes during the patient's stay in the recovery room and she received 300 c.c. of glucose solution intravenously. A Penrose drain had been inserted through a stab wound and sutured into place at the close of the operation. A small amount of bile-like drainage appeared on the dressing and the latter was reinforced before Mrs. White returned to her room.

On the ward, her immediate care proceeded along the same lines. The head of the bed was raised to a moderate height to

facilitate breathing and drainage. The gastric suction was connected and checked for proper function. Intravenous therapy continued; a narcotic — Demerol 75 mgm. — was ordered q.4 h. for control of pain and Dramamine for control of nausea.

Approximately two hours after her return to the ward, Mrs. White was coached in deep breathing and coughing, both hands firmly over her incision to reduce pain. This was followed by bending and stretching exercises for her legs. Breathing exercises and leg exercises were continued q.1 h. for 48 hours during the waking hours.

Mrs. White sat on the edge of her bed the night immediately following operation. Naturally, she experienced weakness and dizziness. The next morning she stood beside her bed and in the afternoon went for a short walk with the help of her nurse. The first two days postoperatively were the hardest for her as far as this part of convalescence was concerned. Within a very short time she was able to walk to the bathroom unaided, and even longer distances.

Voiding proved somewhat of a problem during the first two postoperative days. Catheterization was performed several times but eventually Mrs. White was successful in her efforts. It is possible that residual effects of anesthesia, pre- and postoperative administration of narcotics, pain from her incision, and enforced use of a bedpan, all contributed to her temporary difficulty.

Intravenous therapy continued for three days. The gastric tube was clamped for short intervals and clear fluids given orally as supplementary nourishment. Fruit juices and icecold fluids were avoided since they tend to encourage gas formation. Clear broths and carbonated beverages were more readily tolerated. A light low-fat diet succeeded the use of fluids and was gradually advanced to full fat-free meals.

Drainage from the wound persisted for several days but in gradually diminishing amounts. In the meantime, Mrs. White's nurses checked for any sign of bile retention: jaundice of the sclera; dark yellowish color of urine; failure of stools to return to normal color as drainage diminished. The use of tie tapes made changes of dressing an easy matter and avoided undue irritation to the skin through frequent removal and application of adhesive. Since bile drainage is also an irritant, it was important that the dressings should be replaced at frequent intervals. The Penrose drain was removed when drainage had become minimal.

Health Teaching

The patient who has undergone cholecystectomy usually requires one full month of convalescence before normal activities can be resumed. A special diet is seldom necessary; a normal diet with a minimum of fat is usually quite satisfactory. Principles of good general hygiene should be emphasized — adequate rest, exercise, proper elimination, etc.

Operative procedures in treatment of conditions of the biliary tract have been so well-developed and standardized, that the risk to selected and properly prepared patients is slight. It is felt that if surgery could be carried out when the condition is first diagnosed and before liver damage becomes a factor, that the already low mortality rate in cholecystectomy performed to relieve chronic cholecystitis and cholelithiasis would be further reduced.

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I am not bound to win, but I am bound to be true. I am not bound to succeed, but I am bound to live by the light that I have. I must stand with anybody that stands right, stand with him while he is right, and part with him when he goes wrong.

— Abraham Lincoln

Genius is one per cent inspiration and ninety-nine per cent perspiration.

— Thomas Alva Edison

* * *

There are some who speak one moment before they think.

— Jean De La Bruyère

A Return to Independence

M. KITT

An account of the treatment and nursing care of a patient with a fractured ankle.

Mr. Perry fell on an icy sidewalk after having consumed an excessive amount of alcohol. He was admitted to hospital in a rather dazed condition complaining of severe pain and swelling of the left ankle. X-rays revealed simple fractures of the distal end of the fibula and the tibial malleolus.

The patient was quite alone. He was unmarried, unemployed, and knew no one in our large western city. His only living relatives — an uncle and his mother — resided in the east. At the time of his hospitalization, he was 40 years old — and was fast becoming an alcoholic. He responded well to the warmth and attention he received from the hospital staff.

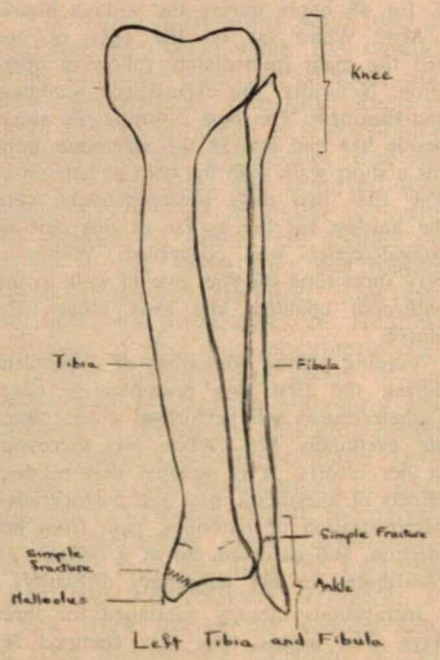
Treatment and Nursing Care

Objectives:

1. The reduction and fixation of the fracture;
2. the maintenance of comfort and good general health;
3. the prevention of complications;
4. extra TLC for a patient who is alone — and who has problems apart from his physical injury;
5. the restoration of function of the ankle.

The fracture was reduced under a local anesthetic, and a plaster-of-paris cast, extending from the toes to the groin was applied to the left limb. The patient was returned to the ward in satisfactory condition.

To maintain correct body alignment, a fracture board had been placed under Mr. Perry's mattress. His left leg was elevated on a pillow to prevent edema, and the cast was left exposed to the air to hasten drying. The nurse examined his toes frequently for any signs of circulatory impairment — numbness, tingling and coldness. The nursing care included special attention to the skin, particularly to areas of irritation or pressure.



Left Tibia and Fibula

Approximately 24 hours after its application, the cast was dry, and had to be "cuffed." This consists of covering both ends of the cast with strips of adhesive tape to avoid chipping of the rough edges — thus preventing injury to the patient's skin. A smooth surface is the result of a properly cuffed cast. This whole procedure was repeated 10 days later when the leg cast was replaced by a shorter one extending to just below the knee.

The tibia is the main weight-bearing

Miss Kitt is a second year student at the school of nursing, Edmonton General Hospital, Alta. This article received Honorable Mention in the Macmillan Award Competition.

bone of the leg. It is sparsely covered with subcutaneous tissue and skin in the lower third. For this reason, circulation is poor and healing is slow. Every effort must be made to build up the patient's strength and resistance to infection.

Because a fractured bone restricts movement and releases an excessive quantity of calcium into the blood stream, renal calculi may form. Nursing measures to prevent this complication included frequent turning of the patient, early ambulation and the forcing of fluids.

The only medications administered for pain were Frosst's 292 tablets (tab. 2 p.r.n.) and, later, Frosst's 217 tablets (tab. 2 p.r.n.). These provided the desired result and allowed Mr. Perry to move about with a minimum of discomfort.

A good nutritive state had to be established. The patient was encouraged to eat a diet rich in protein, vitamins and minerals. This required considerable persuasion, since Mr. Perry, prior to admission had developed poor eating habits — eating irregularly and supplementing his diet with alcohol.

Despite a daily bath and good skin care, a reddened area appeared on the patient's sacral region shortly after the reduction. Generous applications of Alphamel ointment, massage, and frequent change of position helped to remedy this.

Constipation may occur in patients who are relatively inactive. A Dulcolax suppository was ordered p.r.n. for Mr. Perry and this, combined with a diet high in roughage, proved an effective method of maintaining regularity.

Because the patient was rather quiet and withdrawn, he required considerable psychological support. The nurse spent as much time as possible with him and encouraged him to play cards and watch television with other patients. She made arrangements, at his request, for the clergyman of his faith to visit him.

Restoration of function is an important objective of the plan of therapy and nursing care. Mr. Perry understood that atrophy of the muscles involved would result if they were not used. He was able to be up and about in the corridors — using the walker — several times each day. Being able to get about made him feel more content and independent — even though the nurse accompanied him on each trip. Before discharge, the physiotherapist taught him how to use his new crutches.

Mr. Perry was discharged per wheelchair and left the hospital with a broad smile on his face. He was planning to return to clinic to see his physician in the near future. In the meantime, he seemed pleased to be returning to his independent life in the community.

The Nurse and the Geriatric Patient

DIANE SANGSTER

Attracted by the glow of village lamps,
The younger folk have left him with his pipe.
Listening to the wind and crickets call,
He only thinks: The sun has dried the swamps.
The frost has touched the corn, and oats are ripe,
*And in the orchard, fruit begins to fall.**

An overpowering sense of loneliness, hopelessness, and even desolation is conveyed to us upon reading this verse! How accurate is the image of old age as created by this description? Do you agree that this image is all too prevalent in our society today? Much has been said and written about the satisfaction of the physical needs of the elderly patient. The care necessary for persons in this age group is incorporated in all nursing education programs. How many of us, however, have thought about the formation of attitudes in regard to the less tangible side of geriatric care? In this essay, the nurse's attitude and approach to the aged are discussed as well as the actual care that she gives.

THE NURSE'S ATTITUDE

All of us realize that some day, we ourselves will be aged with grey hair, cracked voices, stiff joints and, possibly, with a lower social status. We identify ourselves with the geriatric patient and, as a result we may reject him. Fear is at the root of this rejection.

There are five common attitudes which nurses, as well as the rest of society, may have toward the geriatric patient.

They may reject the idea that old age is honorable. The nurse with this attitude refers to her eighty-year-old male patient as being a "cute little old man" — or calls him "grandpa." A second attitude is the fatalistic one. Here the nurse states, resignedly: "We all have to go sometime." Then there is the nurse who is frightened to contemplate the subject, and who thinks that by isolating the older age group she will not be reminded of the problem of aging. In other words, the aged have lived their lives, so they should stay out of her way. A fourth attitude is observed in those nurses who sense the hopelessness of it all and, although they recognize the enormity of the problem, they surrender to it with no attempt to find a solution. Then there is the group of immature individuals who are in a constant search for adventure. To them geriatric care is not dramatic enough so they leave the patient for someone else to worry about.†

To overcome any of these attitudes, the nurse must, first of all, be emotionally mature herself. No other field of nursing more rigorously tests her maturity and sincerity of purpose. She must realize that the aged are no different from any other age group in our society, except that they have lived longer. If their needs are being met, they will be useful, satisfied citizens in the community. They have much to contribute because of their vast experience. This is the attitude that a nurse who cares for older patients should have.

MEETING THE NEEDS

The psychological needs of old peo-

Miss Sangster was a third year student at St. Boniface General Hospital School of Nursing when she prepared this study. It received Honorable Mention in the 1963 Macmillan Award Competition.

* A passage from Frank Oliver Call's "An Old Habitant."

† Elisabeth G. Phillips, "What it Means to be Old," *The Canadian Nurse*, vol. 52 (Aug. 1956), p. 616.

ple are basically the same as those of any human being of any age: to love and be loved; to secure recognition for personal achievement; to have companionship. These needs were summarized by a member of the Society of Friends who said "Old folk need somewhere to live, something to do, and someone to care." In a hospital setting, the nurse, who spends so much time with her patients, must be one of the individuals who *cares*.

Several anatomic and physiologic changes occur during the aging process. These must be understood if the patient's complete needs are to be met by the nurse:

1. *Changes in the integumentary system.* There is a lessened production of oil and perspiration. This decreases the need for frequent bathing. The use of superfatted soaps will help to prevent excessive skin drying and pruritis.

2. *A decrease in peripheral circulation.* To stimulate circulation and prevent drying of the hands and feet, the patient should be encouraged to massage the parts with a lanolin cream.

3. *Changes in the texture, color and distribution of hair.* The nurse's ingenuity in caring for her patient's hair will be tested. The elderly lady will derive much satisfaction from a stimulating scalp massage, shampoo, and brushing.

4. *Loss of elasticity of connective tissue* results in decreased physical strength and response, and increased rigidity of body structures. The nurse must be patient with the slow-moving person, and, at the same time, employ safety measures to prevent him from falling and injuring himself.

The nurse must make certain that other body needs are being met: an attractive nourishing diet should be served; a quiet environment conducive to rest and sleep should be maintained at night; good body alignment is essential if the patient is bed-ridden; regular bowel and bladder habits should be continued.

The elderly patient — like any other person — likes to be treated as an individual. Only if he is so treated will he respond to the nurse's care.

QUALITIES OF GERIATRIC NURSE

Sympathy, kindliness, and thoughtfulness without pity and a sense of humor are keys to the hearts of the aged. A nurse needs honest tolerance rather than the tongue-in-cheek attitude. Tolerance must be based on the worth of each human being, no matter what his environment or his endowment by nature. Patience and tact are in company with tolerance. Flexibility is another essential quality — for a rigid, authoritarian approach is not in the interest of the older patient. Observational powers, especially in regard to the emotional needs and reactions of the patient, are of great value. If the nurse shows interest in the people the patient knows, talks about, and cares about, she will inspire his confidence and become his friend. Optimism, friendliness, warmth, and genuine interest are the marks of a nurse who truly cares for her geriatric patients.**

It is imperative that we realize that old age does not beget a new personality. It simply brings the patient's true characteristics to the fore. Two basic principles should be remembered: mankind must learn to grow old gracefully, and young people must learn to live with the aged.

Grow old along with me
The best is yet to be,
The last of life
For which the first was made.
ROBERT BROWNING

** Kathleen Newton. *Geriatric Nursing*, Ed. 2, St. Louis, The C.V. Mosby Co., p. 27.

There is a wealth of unexpressed love in the world. It is one of the chief causes of sorrow evoked by death: what might have been said or might have been done that never can be said or done.

— ARTHUR HOPKINS

You can tell the ideals of a nation by its advertisements.

— GEORGE NORMAN DOUGLAS

* * *

An institution is but the lengthened shadow of its leader. — EMERSON

THE WORLD OF NURSING

PREPARED IN YOUR NATIONAL OFFICE, CANADIAN NURSES' ASSOCIATION,
74 STANLEY AVENUE, OTTAWA

NURSING AND THE CENTENNIAL

IN JUST FOUR YEARS FROM THIS MONTH WE WILL BLOW OUT THE CANDLES ON CANADA'S 100TH BIRTHDAY CAKE. THIS MONTH NATIONAL OFFICE REFLECTS ON WHAT NURSES CAN DO TO MARK THIS HISTORIC OCCASION.

No one would dispute the fact that it has been a tough job to make Canada what it is today, least of all those in the nursing profession who know full well the hardships endured to bring nursing thus far. Nursing in this country is an integral part of Canada's history. In fact, it is written that the early French nurses provided a liaison between French and English which made it easier to lay the foundations for a united Canada. Should nursing not then play a role in the 1967 celebrations of this united Canada?

Every Canadian has been invited to become a planner for the Centenary of Canada. JOHN FISHER, commissioner of the National Centennial Administration, views it as the greatest opportunity for every individual and every group in a city or town to join forces to mark this anniversary. As he says,

> Each Canadian should have a centennial plan of his own, whether it be a trip to another part of Canada, painting the house, cleaning the property, planting flowers and trees, or building a new porch. Budgeting for scholarships, purchasing books or planning a neighborhood party, are mere suggestions. Each and every Canadian should realize that what he or she does will add to the estate of Canada.

But what, you say, can nurses do to add to the estate of Canada?

Perhaps hearing something about the aims and objectives of the centennial program and of some of the projects that are being evolved by groups large and small might help us crystallize our thoughts and establish projects of our own.

No one is dictating to Canadians how they should celebrate the 100th birthday. But trying to get all Canadians to participate enthusiastically is one of the major tasks of the National Centennial Administration.

Official government planning for the centennial observations began back in 1959 when the Prime Minister asked the Premiers of all provinces to appoint representatives to a provisional national committee. The following February the inaugural meeting of the National Committee on Canada's Centennial was held with all ten provinces and the Federal government represented. This first meeting agreed on the general objectives of the Centennial program:

> to promote interest in, and to plan and implement programs and projects relating to, the Centennial of Confederation of Canada in order that the Centennial may be observed throughout Canada in a manner in keeping with its national and historic significance.

In June of 1960 the Prime Minister, from the floor of the House of Commons, invited citizens to submit suggestions for the Centenary.

You have already heard and read about some of the Federal projects. For instance, the Mile of Living His-

tory which involves the restoration by the National Capital Commission of a four-block stretch of Sussex Drive in Ottawa to give to this section of the city the fine appearance of the Confederation era when it was the main commercial street of our national capital . . . The Fathers of Confederation Memorial Buildings project at Charlottetown . . . The building of the Canadian Historical Museum in Ottawa to record and portray the story of the settlement and development of Canada from the days of the aborigines to our own day.

Perhaps you haven't heard about some of the individual projects that are already underway — projects by corporations, associations, business groups, and women's organizations.

The Bank of Montreal in 1960 devised a seven-year series of Canada Centennial Scholarships for the study of the Arts and the Sciences to assist in developing a number of young Canadian men and women into outstanding citizens. In all there will be 124 grants made over the seven-year period, culminating in the year of Canada's Centenary.

Cities Service Oil Company has planned a 6-1/2 acre garden at Bronte, Ontario, featuring plants, flowers and shrubs from every province in the Dominion. This living monument will be enjoyed by generations of Canadians.

The Canadian Medical Association has proposed a permanent national health museum in Montreal. Some groups are writing histories; some are giving their communities a "face-lifting"; others are planning international meetings. Then there is a women's group in Nova Scotia who have come up with quite a unique project. They have set up programs for taxi drivers and waitresses in their towns to learn all they can about the province of Nova Scotia so that they will be able to be real hosts to visiting tourists.

Nursing could provide inspiring vistas for many centennial projects across Canada. All it takes, says John Fisher, is elbow grease, enthusiasm and coordination; three ingredients nurses have never lacked.

We in National Office have made a start with the production of film to speak for the nursing profession across Canada. In the script stage at the moment, this film will be primarily for the general public.

Perhaps in this 96th birthday month we might think about this country of ours and how we can share in the centennial theme "to build a better Canada."

Motivation: Key to Attracting and Retaining Executives.

BENJAMIN M. HINES, Director of Personnel Planning, General Foods Corp., holds that "since compensation, the prime motivating factor, has become a magnet of uniform strength for almost all companies (they offer just about the same financial incentives) we must look to other motivational factors to inspire top performance."

Executives are properly motivated, Hines suggests, when:

1. They are convinced that they are performing useful and challenging work.

2. They share a feeling of enthusiasm and optimism about the aims and capability of company management.

3. They respect the ability and understanding of their immediate supervisor.

4. They know the objectives, responsibilities, and standards of acceptable performance connected with their jobs.

5. They have a chance to take part in formulating goals, policies, organization, and procedures related to their activities.

6. They are free from fear of whimsical or capricious actions that will end their jobs.

7. They are provided with the possibility of advancement in salary and position, if deserved.

— *Office Overload Management Tips*

Nursing Profiles

Sister Margaret Mooney, former director of the school of nursing, Hotel Dieu Hospital, Kingston, has been appointed assistant director of the school of nursing,

SISTER MARGARET MOONEY

University of Ottawa. She recently completed requirements for her Master's degree in nursing from the University of St. Louis, Missouri. Sister is a graduate of Hotel Dieu Hospital, Cornwall, Ont. and a former instructor and director of nursing of the same institution. She is the representative to the CNA Executive Committee from the religious sisterhoods of Ontario.

The University of Western Ontario School of Nursing has welcomed several new staff members during the past months. **Amy E. Griffin,** a graduate of Hamilton General Hospital, was appointed assistant professor and director of nursing research during 1962. Miss Griffin obtained her B.A. from University of Toronto and her M.Sc. from Wayne State University, Detroit. She has since completed the course and examination requirements for a doctorate in education from Columbia University. She has had wide experience in nursing education, having been associated with the educational pro-

(Ashley & Crippen, Toronto)

AMY GRIFFIN

grams of Oshawa General Hospital, McMaster University School of Nursing, Wayne State University and the Atkinson School of Nursing, Toronto Western Hospital. **Shirley Ruth Good,** lecturer in nursing service administration, is a graduate of Women's College Hospital, Toronto. She obtained her B.S.N. degree in 1959 and completed requirements for a Master's degree in educa-

SHIRLEY GOOD

tion from Drury College, Springfield, Missouri in 1961. Miss Good obtained much of her experience on the staff of Springfield Baptist Hospital where she moved up successively from the position of acting director, nursing education and medical nursing instructor, to that of associate director, nursing education before returning to Canada to

LOUISE BROWN

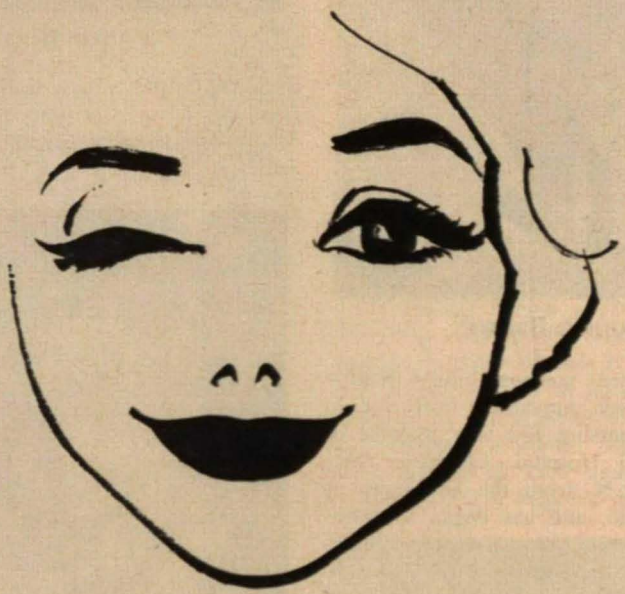
accept her present position. **Louise Sophia Brown** has been appointed instructor in public health nursing. She is a graduate of Public General Hospital, Chatham, Ont.; holds her B.Sc.N. from the University of Western Ontario, and has begun to fulfill requirements for a Master's degree in public health from the University of Michigan, Ann Arbor. Miss Brown was supervisor in public health nursing for St. Catharines-Lincoln health unit before accepting her present position. **Ethel Horn,** a graduate of Newark City Hospital, New Jersey, joined the staff as assistant professor of public health nursing. Miss Horn obtained her Master of Arts degree from Columbia University and has had many years experience in the public health field with the Visiting Nurse Association in New Haven and Brooklyn and the Detroit Health Department where she rose to the position of special supervisor. Mrs. **Vivian Wood,** who is instructor in nursing education, is a graduate of Hamilton General Hospital. She obtained her B.Sc.N. from the University of Western Ontario and has had graduate work at Boston University. Mrs. Wood was formerly

VIVIAN HOOD

a clinical instructor at St. Catharines General Hospital, Victoria Hospital, London, and Mt. Auburn Hospital, Cambridge, Massachusetts.

EDITH M. MCDOWELL

Edith M. McDowell, the first vice-president of the RNAO, was recently appointed special advisor to the Canadian Conference of Catholic School of Nursing. Dean of the school of nursing, University of Western Ontario during the years 1947-59, Miss McDowell later directed the development of the Master's program in nursing at UWO under the sponsorship of the W. K. Kellogg Foundation. She was awarded an honorary Doctor of Laws by the University of Western Ontario in 1962.



Keep your Eye

on this Space

in the August Issue!

M. Phyllis Conway, a graduate of the diploma course in nursing, University of Ottawa, 1947, and in nursing education from the same institution in 1960, has been appointed executive secretary of the Canadian Conference of Catholic Schools of Nursing, replacing **Mary Berthe**. Miss Conway took postgraduate preparation in operating room technique and management at St. Michael's Hospital, Toronto. She is a former assistant director of nursing of the Ottawa General Hospital.

Beatrice M. Allen, principal of the school of nursing of Plummer Memorial Hospital, Sault Ste Marie, Ont. from 1951-62 and a member of the teaching staff for four years prior to that, retired from active nursing last year. A graduate of the Oshawa General Hospital, Ont., Miss Allen was associated with Kitchener-Waterloo Hospital for 12 years. The appreciation felt for her years of service to PMH was evidenced in the presentations and social activities that marked her retirement.

In Memoriam

Alexandra (Cadieux) Briere (Notre Dame Hospital, Montreal '31) died suddenly in February of this year.

* * *

The Alumnae Association of Sherbrooke Hospital, Que. reports the loss through death of the following graduates: **Jean (Fenton) Cromwell** '27, after a long illness and **Barbara Clare (Farnsworth) Simpson** '57.

* * *

Pierrette Doutre (Notre Dame Hospital, Montreal '61) died suddenly in March, 1963.

* * *

Mary M. Elliott (Winnipeg General Hospital '95) died in Vancouver on March 12, 1963.

* * *

Margaret Colbert Gleeson (Butler Hospital, Providence, R.I.) died in Saint John, N.B. on March 19, 1963.

* * *

Lorraine Lanteigne (Hôtel-Dieu of Campbellton, N.B.) died suddenly on March 17, 1963.

* * *

Elspeth A. (Grant) MacGregor (Cornwall General Hospital '14) died in Cornwall on February 7, 1963.

* * *

Pearl Margaret Aird (Gilbert) Marshall (Ontario Hospital, Whitby '44) died during January, 1963 in Brampton, Ont.

* * *

Yvonne (Letellier) Mineau (Ottawa General Hospital '25) died recently. She had engaged in private nursing.

* * *

The Alumnae Association of Hamilton General Hospital pays tribute to the memory of the following graduates: **Helen Esther Knechtel** '28, **Elizabeth A. McLeish** '04 and **Christena (McBeth) Murdoch** '40.

* * *

Alice Priscilla (Reynolds) Osborne (Edmonton General Hospital '36) died in Cold Lake, Alta. on March 13, 1963. She was a former matron of Kerrobert Union Hospital, Sask.

* * *

Edna E. (Watson) Rainnie (Chipman Memorial Hospital, St. Stephen, N.B. '19) died in March 1963. She was a charter member of her hospital alumnae.

* * *

Margaret May (Harvey) Rendall (St. Catharines General Hospital, Ont. '41) died during January, 1963. She had engaged in institutional nursing.

* * *

Alice (Rayner) Turner (Lying-In Hospital, Boston) died recently in O'Leary, Prince Co., P.E.I. She operated the Turner Nursing Home for 35 years, retiring when the Community Hospital, O'Leary, opened six years ago. Mrs. Turner was in her 81st year.

* * *

Mary Amelia Walsh (Moncton Hospital, N.B. '26) died in Moncton during January 1963. She was a staff member of Jordan Memorial Sanatorium, The Glades, N.B.

A Repaired Heart

LAURIE GRANT

A nurse's observations of a 12-hour-old baby lead to the discovery of a serious heart defect — pulmonary stenosis.

Congenital heart disease is said to cause more deaths in the first year of life than any other congenital defect. The six defects most commonly affecting the heart of the newborn are:

1. Atrial septal defect.
2. Ventricular septal defects.
3. Patent ductus arteriosus.
4. Transposition of the great vessels.
5. Coarctation of the aorta.
6. Pulmonary stenosis.

The etiology of cardiac defects is, in many cases, unknown. There are, however, certain factors that contribute to their incidence:

1. German measles, if contracted by the mother during the first trimester of pregnancy;
2. Vitamin A deficiency during pregnancy;
3. Heredity.

Frequently, other congenital disorders are seen in children who have a heart defect. Some of these are: mongolism — often associated with an atrial septal defect; cataracts; deafness; and skeletal defects.

Baby George, a beautiful nine-pound boy, appeared to be normal in all respects. His color was good, his reflexes were normal, and he was very active. Twelve hours after his birth, the nurse noticed that he appeared to be slightly cyanosed. She stimulated him to cry, believing that his color would improve with greater lung expansion. This was ineffective and, to the alarm of all concerned, the cyanosis persisted. He was sent at once to a children's hospital where he was placed in an isolette on the emergency ward for the newborn.

On examination it was noted that he had severe cyanosis, peripheral edema, slight clubbing of the fingers and toes, dyspnea, and a systolic murmur. A tentative diagnosis of pulmonary stenosis was made and instructions were given to continue to keep him in the isolette with oxygen.

Pulmonic stenosis is of four general types: valvular, infundibular, pulmonary arterial and combined.* Baby George's defect was classified as pulmonary *valvular* stenosis. This condition causes increased pressure in the right ventricle and decreased pressure in the pulmonary artery, leading to possible right-sided heart failure. The prognosis depends on the degree of obstruction. Operative mortality is increased when congestive failure is present.

George's condition did not improve in spite of oxygen therapy, but he took his feedings eagerly and seemed to be able to tolerate being out of oxygen for short periods. The physician decided that he would be able to withstand diagnostic tests.

VERIFYING THE DIAGNOSIS

A chest x-ray was taken to determine the heart size and the lung vascularity. The heart was considerably enlarged with decreased lung vascularity.

Cardiac catheterization provided a more accurate diagnosis. The infant was given a mixture including largactil, demerol and phenergan to produce sedation. An incision was made into the

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Miss Grant was a student at the Hospital for Sick Children, Toronto, Ont. when she wrote this article.

* Loyal Davis, ed., *Christopher's Textbook of Surgery*, Phila., W.B. Saunders Co., 1960, p. 437.

groin to locate the great saphenous vein, and a sterile radiopaque catheter was inserted into the vein and passed up to the heart chambers. Here, the pressure and blood samples were taken. In pulmonary stenosis, the pressure is increased in the right ventricle and decreased in the pulmonary artery. The right ventricle pressure was 115 mm. of mercury, compared to the normal of 30. It was not possible to read the pressure in the pulmonary artery as the catheter would not pass through the narrowed valve. A continuous electrocardiogram was made.

An angiogram was taken at the same time as the catheterization and this too revealed a stenosis. A radiopaque dye, injected intravenously, outlined the heart chambers and the large blood vessels, giving the physicians a clearer picture of the defect.

Thus the diagnosis of pulmonary valvular stenosis was confirmed. A valvulotomy was planned for the following day even though the operative risk was high.

In this operation, usually performed under hypothermia, the pulmonary artery is opened until the valve is visible. The stenosis is reduced by cutting the valve with a valvutome.

NURSING CARE

Following heart surgery, three important principles of postoperative care should be followed. The first is to assist a baby to obtain and maintain full lung expansion. For this reason he returns from surgery with closed chest drainage in place, and will be given oxygen with high humidity. This is helpful in loosening the secretions which form in the bronchi. Frequent suctioning, stimulation to cry, and regular changing of position are necessary in order to maintain a free airway.

The second principle is to prevent dehydration and promote nutrition. Oral feedings are withheld for twenty-four hours, or longer if necessary. Intravenous fluid is given, but is run at a very slow rate, so that the heart will not have too great a volume to pump.

The last principle is recognition of possible complications which should be reported at once. Complications that might arise are: pneumonia, atelectasis, pneumothorax, or an embolism; heart failure, cardiac arrest, or heart block. Blood pressure is checked every 15 minutes for the first six hours, then every two hours for the next 18 hours, and then every four hours. Pulse and respirations are watched closely every 15 minutes at first, then every hour, and then every four hours. Temperature is usually taken every four hours. The color of the face, nails, and mucous membrane of the mouth should be noted. The incision line should be checked for bleeding, discharge, inflammation, edema or bruising. The character and amount of drainage and suction is an important observation.

Baby George did very well postoperatively. His color was improved, his activity and cry strong, his heart regular and his lungs clear. An x-ray showed his heart to be smaller but his lungs were still avascular. A few days later he was returned from the recovery room to the ward. He still appeared slightly cyanosed, but he took his feedings eagerly and appeared to breathe more easily than before his operation. The incision line was healing well and he was very active.

He was discharged home at three weeks of age. No special care, except extra precaution to keep him free from infections, was necessary. He should have a well-balanced diet with a supplement of iron and vitamins during his first few years. His immunization program should be carried out according to schedule. With routine check-ups his future should be that of any normal boy.

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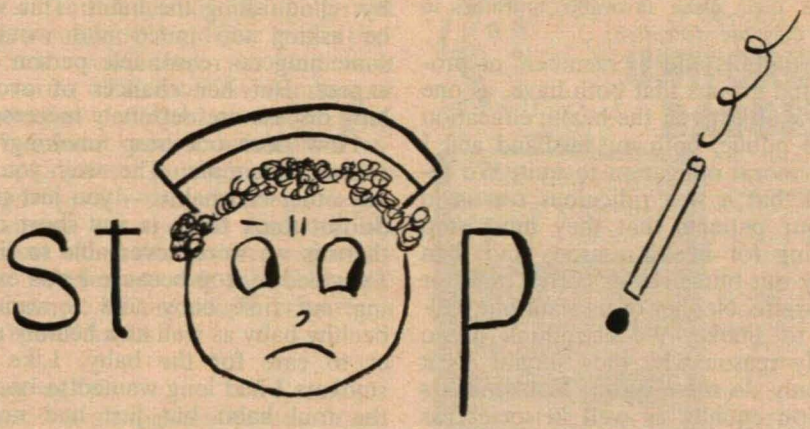
Love and scandal are the best sweeteners of tea. — HENRY FIELDING



MONICA ANGUS, B.S.N.

As members of a health profession that is concerned with the preventive as well as the treatment and rehabilitative aspects of disease, nurses who smoke have a responsibility to relinquish the habit.

Five years ago, I stopped smoking. Three years ago, my husband, a doctor and an addict to cigarettes for 17 years, also stopped. Neither of us would say that to give up this habit was easy — it was not. We are now convinced, however, that giving it up has been one of the most worthwhile things we have done — for our children, our professions, and for our health.

Studies have revealed a definite link between carcinoma of the lung and cigarette smoking. They have also shown that the incidence of other diseases, such as heart and vascular disease, stomach ulcers, sinusitis, bronchitis, etc. is also higher in smokers than in non-smokers. It is difficult to understand why anyone concerned with the health of the body — such as we assume a nurse to be — would go on inhaling the poisonous fumes of disease.

Some smokers argue that psychologically they need the gratification given to them by the cigarette. They say, as I used to, "smoking is a relaxing pleasure," and they thus continue to promote a very harmful practice. One medical writer* contends that the false image created by the smoker is an infection which can easily be transmitted to other people:

> The desire to smoke originates from the advocacy of smoking by smokers, much of it unconscious. Each time a smoker lights up, he says in effect, "I am in favor of the smoking of tobacco, I approve of smoking;" and little weight attaches to any mere words he may utter in contradiction to his actions. Each profferred cigarette, each word of approval of smoking, written or verbal, is smoking propaganda. Every smoker is, in fact, whether he (or she) wills it or not, a living advertisement for tobacco. There are so many smokers today, and they smoke and speak encouragement to smoke so often, that the persuasive pressure on non-smokers to commence or recommence smoking is powerful indeed... Psychological "infection" of the non-smoker is completed, as a rule, by the intimate persuasion of a smoker; "one has to have a bit of pleasure (or comfort) these days; or "one has to have one little vice; it doesn't do to be too good." Besides simple persuasion reinforced by example and free samples, smokers use — though as a rule without realizing it — less ethical methods of infecting non-smokers. Thus they suppress the facts, particularly the more

Mrs. Angus is a graduate of St. Paul's School of Nursing, Vancouver, B.C. and the University of British Columbia School of Nursing.

* Lennox. Johnston, *Lancet* (Feb. 1952) p. 480.

damning facts, against smoking, and circulate in their place favorable untruths; in short, they use *deception*.

As parents and as members of professional groups that both have, as one of their objectives, the health education of the public, both my husband and I felt a moral obligation to quit. We realized that it was ridiculous for us to tell our patients that they must stop smoking for health reasons and then scurry out ourselves at coffee time for a cigarette. Neither of us want our children to smoke. We can think of no earthly reason why they should — it can only do them harm. Non-smokers function equally as well in society as smokers do — at least no learned people are able to tell us otherwise. As parents, we felt that we could not justify our thinking about our children not smoking unless we stopped smoking ourselves.

We were impressed with an extensive study** undertaken in recent years in the U.S.A. which revealed that the smoking habits of students are directly related to parental smoking behavior. The study indicated that the seed for smoking was planted in the children by the parents and other influential adults *such as doctors and nurses* (italics are mine). How then can nurses justify smoking when they are attempting to teach good health habits? If my children are taught health habits by a nicotine-fingered, cigarette-smoking nurse at school, I will not be surprised if they think both the lesson and the nurse a paradox. My sincere wish is that my example will be reinforced by the good example of the nurse and the teachers at the school.

It is believed that if one has smoked for ten years or more, definite changes will take place in the lungs. If, however, the individual stops smoking, the changes will reverse themselves in time to normal lung tissue. So the oft-heard argument, "it is too late for me now, I have been smoking for too long," is just so much nonsense. No one can, of course, guarantee that the long-time smoker is going to *prevent* lung disease by relinquishing the habit. This would be asking too much and would be something no reasonable person could expect. But her chances of avoiding lung disease are definitely increased.

How does one stop smoking? The answer is simple: The way you stop any other bad habit — you just stop. I do not think there is any short cut; if there is we were never able to find it. I decided to stop because I was expecting my first baby and I wanted a healthy baby as well as a healthy mother to care for the baby. Like most smokers I had long wanted to be rid of the foul habit but just had not got around to steeling myself to the withdrawal period. When I stopped, I had no desire, as some do, to be chewing gum or eating, but I did find that my hands were fidgety. I wanted to hold something, to be doing something with them. The process of wanting and denying a cigarette went on for several weeks. Occasionally, I had a puff and found to my great pleasure that I did not want another. Indeed, I was able to convince myself that I did not even like the taste. After a month or two it became a thing of the almost forgotten past. A coffee break became the ultimate proof that *I* had conquered and the *cigarette* had lost. Now I am not concerned about my hands. They do the things they did before I took up smoking and I do not notice them unless I tell them to do something. I feel confident that I will not return to the ranks of the smoker.

My husband found the withdrawal much more difficult. His measure of relief was the occasional cigar — an admirable measure for men but one which I do not recommend for nurses. The odor of the cigar is, I am sure, one that no lady would desire to carry around with her. There is a drug on the market that might help some smokers. The only people I have ever spoken to who have taken this drug feel that the after-effects were much the same as the after-effects of smoking too many cigarettes and that if they had their choice they would rather have had the hang-over from the real thing.

Summary

Recently, there has been much pub-

** M.B. Haenszel, H.B. Shimkin, and H.P. Miller. *Tobacco Smoking Habits in the United States*, Dept. of Health, Educ. and Welfare, Public Health Monograph No. 45, Govt. Printing Office, Washington, D.C.

licity about the positive relationship between carcinoma of the lung and cigarette smoking. Evidence is also present that would link smoking with other forms of disease. As members of a profession dedicated to the preventive, treatment and rehabilitative aspects of disease, nurses must concern themselves with this smoking hazard. Each nurse has a moral responsibility to insure that the public, especially young people, are not misled by the bad example of the people who teach good health habits.

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WHO SMOKES?

Ever since the days of Sir Walter Raleigh, the dried leaf of *Nicotiana tabacum*, also known as "divine tobacco" (Spenser) and a "dirty weed," has been burned and its smoke inhaled in fantastic amounts all over the world. Clearly, man finds some type of gratification in smoking, or else it fills a need not otherwise met. Whether it is a "vice," a habit, a tranquilizer, an oral gratification-substitute, or a drug, smoking is so commonplace as to be accepted as much a part of living as the toothbrush or the cup of coffee.

But, not every one smokes. Why is this? Is there a difference in type between the smoker and the non-smoker? This problem has intrigued a number of psychologists and psychiatrists for some time, and what follows is a survey of their observations.

Personality

There are at least three hypotheses which relate personality with smoking: (1) The more extroverted a subject is, the more (cigarettes) he smokes; this is based on the concept that the extrovert concentrates on objects in the outside world. (2) The more motor and sensory habit, it reduces the strength of an aroused emotion. (3) The emotionally unstable and neurotic the subject is, the heavier he smokes, because, as a more rigid and puritanical the person, the less the smoking, because smoking, like other pleasurable activities, may be regarded as "slightly sinful" and hence shunned.

In a study of 2,360 male subjects, selected according to smoking habits, age, and social level, the first hypothesis was confirmed; that is, the statistical analysis of personality types, as determined by questionnaire and smoking habits, revealed that extroverts are heavier smokers than introverts. The study only weakly supported the thesis that non-smokers are more rigid than those who do indulge, and no statistical support was given to the hypothesis that smokers are more neurotic than non-smokers. Pipe

smokers, perhaps not unexpectedly, were more introverted than others.

The heavy smoker is said to belong to a group that has an aversion to strenuous exercise and sports, exhibits a lower degree of physical fitness, is more sensitive in affect, and possesses greater instability of autonomic nervous function. "They are apt to be less well integrated and more ideational, creative, and intuitive . . . Academically, they most often select the area of arts, letters, and philosophy as a college major."

Social Traits

Personality and social traits of a large representative group of adults (over 4,000) in Buffalo, New York, were the subject of an interesting survey by Lilienfeld. The smokers and nonsmokers were matched according to age, sex, race, and social level. The answers to a questionnaire revealed that the (cigarette) smokers

marry more often
move more frequently
change jobs more often
are hospitalized more often
participate in more sports

No dissimilarities were noted with respect to birthplace, religion, education, or urbanization. However, it apeared that a significantly larger proportion of parents of nonsmokers were born outside that country.

Some statistically significant differences in emotional state were uncovered. For example, nonsmokers were more likely to answer "never" to such questions as: "Do you ever feel like smashing things for no good reason? Does it make you sore to have people tell you what to do? Do your hands ever tremble enough to bother you?"

Several interpretations are possible: (1) Cigarette smoking may be a cause of these characteristics; (2) such so-called neurotic traits may lead to the smoking habit; and (3) both smoking and these traits result from common underlying factors. The true situation remains unclear.

The fact that a person smokes, or does not, seems to be determined not only by what may be called "personality" but also by his social milieu. Nonsmokers tend to be lower middle class in origin but are moving upward in social status; they are earnest and have been bred in a climate of morality that stresses work, ambition, and improvement. Their parents, and they themselves, are often pious.

Smokers, on the other hand are likely to come from more privileged backgrounds and often have been reared on a code of traditional, acceptable behavior. Only 20 per cent of the graduates of very exclusive preparatory schools do not smoke as compared with 40 per cent of public school graduates.

Nonsmoking is closely associated with nondrinking. Individuals who neither drink nor smoke prefer "nights at home" to "nights out" and belong to a few organizations rather than to many. They are, in the words of Riesman, more "inner-directed" and less likely to go along with the pressures of mass media.

One can offer a tentative hypothesis. Starting to smoke is largely brought about

by one's social environment, but continuing the habit depends in good part on the personal need that smoking can satisfy. Anxious people may use smoking as a tension reducer; compulsive people may use it as part of their pattern of restless activity.

Discussion

A clear-cut smoker's personality has not emerged from the results thus far published. This is not surprising, because approximately 60 million persons in the United States over age 18 smoke, and it is hard to believe they would share one personality type. However, "it is possible to think that there may be in certain individuals a biological or *genetic predisposition* to a strong desire to smoke." None of the published studies has identified a single variable found exclusively in one group and absent in the other, but group trends apparently exist. Multiple factors rather than a single personality or genotype factor may be at work.

One must not make the *post hoc, ergo propter hoc* error. Even if relationships between smoking and personality variables are found, they need not be causally related. "There is as much reason to suppose that cigarette smoking causes nervous tension as to believe that nervous tension causes cigarette smoking." A similar statement could be made about other characteristics. In addition, the factors at work in starting to smoke may be, and probably are, quite different from those which perpetuate the habit.

In short, smokers and nonsmokers differ in a number of personal, social, and behavioral characteristics, but just why some smoke and others do not remains to be answered. At any rate, it seems that where there is smoke there is fire.

— *Physician's Bulletin*, Vol. 27, No. 3,

* * *

The short period of life is long enough for living well and honorably.

— MARCUS TULLIUS CICERO

In the Good Old Days

(*The Canadian Nurse* — JULY *1923*)

Anyone who is intelligently interested in children realizes the importance of "self-activity" in any scheme of education. As Spencer puts it, "The vital principle is to enable the pupil rightly to instruct himself." Children should be *told* as little as possible and induced to *discover* as much as possible. Any method which we may use must be checked up by the question, "Does it create a pleasurable excitement in the pupil?" For a child's intellectual instincts are always trustworthy. Everyone knows that things read, heard or seen with interest are better remembered than those read, heard or seen with apathy.

* * *

The primary need of an infant is a competent mother. Motherhood is a profession. Every expectant mother should prepare herself to take up her work as seriously as she would if she were choosing a profession and preparing herself to enter a field of public activity.

* * *

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* * *

There are big tasks lying before women—tasks that call for such wisdom as we get by combined study; tasks that need the altruism we get in working together; tasks that need the energy we get from combination of effort. We want homes where the big things are made big and the little things unimportant. We want communities that are extensions of the home, where we shall be friends, we people of all races and creeds. We must have the vision to stand together nation-wide.

How to Organize and Extend Community Nursing Services for the Care of the Sick at Home. National League for Nursing, Inc., 10 Columbus Circle, New York 19, New York. 1962.

This publication is a report of a series of regional conferences conducted by NLN's Department of Public Health Nursing. Also included are guidelines on how communities can obtain necessary home nursing services; functions of board and advisory committees; sample constitution and by-laws for a voluntary agency; standing rules for an advisory committee; and criteria for evaluating the administration of a public health nursings service.

Baillière's Midwives' Dictionary by Vera Da Cruz, S.R.N., S.C.M., M.T.D. 394 pages. The Macmillan Company of Canada Limited, 70 Bond Street, Toronto. 1962.

This fourth edition incorporates new terms and definitions relating to the emotional aspect of childbirth. A new appendix "devoted to the psychological features of childbearing" has been added.

The Work, Responsibilities and Status of the Enrolled Nurse. 60 pages. Dan Mason Nursing Research Committee of the National Florence Nightingale Memorial Committee of Great Britain and Northern Ireland, London, 1962.

This manual examines the position and role of the enrolled assistant nurse who works in the National Health Service.

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Registered Nurses, Certified Nursing Assistants (IMMEDIATELY) for 40-bed hospital in pleasant town of 5,000. 42-hr. wk. with good rotation shifts, providing long weekends every 4 wks. Good salaries and personnel policies. For further details and application, apply: Administrator, General Hospital, Espanola, Ontario. 7-41-1

Registered Nurses and Certified Nursing Assistants for 160-bed accredited hospital. Starting salary $340 and $235 respectively with regular annual increments for both. Excellent personnel policies. Residence accommodation available. Assistance with transportation can be arranged. Apply to: Director of Nursing, Kirkland & District Hospital, Kirkland Lake, Ontario. 7-67-1

Registered Nurses and Certified Nursing Assistants for immediate and future vacancies in this 42-bed hospital. Starting salaries $335 and $225, respectively. Accommodation in new residence available. Usual fringe benefits. For full information, apply to: Director of Nursing, New Liskeard and District Hospital, New Liskeard, Ontario. 7-83-1

Registered Nurses and Certified Nursing Assistants for 26-bed hospital. R.N. minimum salary $340, maximum $380, 28-day vacation after 1-yr. C.N.A. minimum salary $244, maximum $275, good personnel policies, 2-wk. vacation after 1-yr., 3-wk. after 2 yrs. Credit for past experience, $5.00 increment every 6 mo., 40-hr. wk. 8 statutory holidays. Room & board $45 per mo., 1-day sick leave per mo. Apply to: Mrs. G. Gordon, Superintendent, District Memorial Hospital, Box 37, Nipigon, Ontario. 7-87-1

Registered Nurses and Registered Nursing Assistants for 60-bed hospital. Excellent personnel policies includes 5-day wk., 8 statutory holidays and pension plan. The town has a fine quarry for your swimming pleasure and Stratford's Shakespearian Festival is only a few miles away. Apply: Superintendent, Memorial Hospital, St. Marys, Ontario. 7-112-1

Registered Nurses and Qualified Nursing Assistants for 15-bed very active modern hospital in Niagara Peninsula 12-mi. from the Famous Niagara Falls. Personnel policies and salaries in line with other local hospitals. Apply stating qualifications, experience, date available and telephone number to: Administrator, Medical Centre Hospital, Box 10, Virgil, Ontario. 7-137-1

Registered Nurses for General Duty in well-equipped 28-bed hospital, located in growing gold mining and tourist area, north of Kenora, Ontario. Modern residence with individual rooms; room, board and uniform laundry only $45. 40-hr. wk., no split shift, cumulative sick time, 8 statutory holidays and 28 day paid vacation after one year. Salary range $350 - $375. Apply to: Matron, Margaret Cochenour Memorial Hospital, Cochenour, Ontario. 7-29-1

Registered Nurses for General Duty in all departments including premature and new-born nursery, Isolation Emergency and Recovery Room. Good salary and personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario. 7-73-10

Registered Nurses for General Duty & Operating Room in modern hospital (opened in 1956). Situated in the Nickel Capital of the world, pop. 80,000 people. **Salary: $325 per mo.** with annual merit increments, plus **annual bonus plan,** 40-hr. wk. **Recognition for experience. Good personnel policies. Assistance with transportation can be arranged.** Apply: Director of Nursing, Memorial Hospital, **Sudbury,** Ontario. 7-127-4

Registered or Graduate Nurses for modern 100-bed hospital located in summer resort district, 40-mi. from Ottawa. Apply: Director of Nursing, Public Hospital, Smiths Falls, Ontario. 7-120-2

General Duty Registered Nurses for surgical, medical and obstetrical wards. Small sized hospital near Ottawa. Apply to: Superintendent, Kemptville District Hospital, Kemptville, Ontario. 7-63-1

General Duty Nurses for an accredited 66-bed hospital. Starting salary: $325. Excellent personnel policies, pension plan, residence accommodation only 10 min. from downtown Buffalo. Apply: Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario. 7-45-1

General Duty Nurses for new 70-bed hospital in Muskoka District. Starting salary $305/m., good personnel policies. Apply: Director of Nursing, Huntsville District Memorial Hospital, Huntsville, Ontario. 7-59-1

General Duty Nurses for modern 100-bed hospital. Registered Nurses $315-$345 per mo., Graduates $250-$295; 40-hr. wk., benefits include accident, sickness and life insurance, hospital and medical insurance plans, & OHA Pension Plan. Apply: Miss Tillett, Director of Nursing, Leamington District Memorial Hospital, Leamington, Ontario. 7-69-1

General Duty Nurses for 100-bed modern hospital, southwestern Ontario, 32 mi. from London. Salary commensurate with experience & ability; $300 basic salary. Residence accommodation available. Pension plan. Apply giving full particulars to: The Director of Nurses, District Memorial Hospital, Tillsonburg, Ontario. 7-131-1

General Duty Nurses Male & Female & Certified Nursing Assistants (Immediately) for 86-bed hospital, 40-hr. wk., 8 statutory holidays & other employee benefits. Collingwood is situated on Georgian Bay & is noted as a vacationland with 7-mi. sand beach and great skiing on the Blue Mountains in winter. For further information apply: Director of Nursing Services, General and Marine Hospital, Collingwood, Ontario. 7-31-1

General Duty Nurses & Certified Nursing Assistants for new 50-bed hospital with modern equipment. 40-hr. wk., 8 statutory holidays, excellent personnel policies & opportunity for advancement. Tourist town on Georgian Bay. Good bus connections to Toronto. Apply to: Director of Nurses, General Hospital, Meaford, Ontario. 7-79-1

Operating Room Nurses for general operating room work which includes cardiovascular, neurosurgery, genito-urinary, ear, eye, nose and throat and orthopedic surgery. Good salary and personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario. 7-73-10A

Public Health Nurse for a completely generalized program. Salary range, pension plan and other personnel data gladly supplied on request. Applicant must have car. Apply to: Dr. W. H. Cross, Director, Muskoka District Health Unit, Box 1019, Bracebridge, Ontario. 7-15-2

Public Health Nurses (Qualified) for generalized public health program. Allowance for experience. 4-wk. vacation, car allowance, pension plan, hospitalization and P.S.I. For further information write: Dr. G. Murray Fraser, Director, Brant County Health Unit, Brantford, Ontario. 7-17-4

Public Health Nurses (Qualified) for generalized program by Stormont, Dundas and Glengarry Health Unit, located in the Seaway Valley area. Minimum salary $3,700 with a commensurate increase upon satisfactory completion of 12 mo. service. Allowance for experience. 5-day wk. P.S.I. Employer-shared group insurance, pension plan and Ontario hospital insurance. 3-wk. vacation. Cumulative sick leave credits, 1/2 paid as bonus upon separation after 3-yr. service Generous car allowance. Apply in writing giving full particulars to: Miss Glenna French, Supervisor of Nursing, Box 1058, Cornwall, Ontario. 7-34-5

Public Health Nurses (Qualified) for generalized program in a highly urbanized and rural area. Salary: $3,900 to $4,650. For further information apply to: Dr. A. F. Bull, Medical Officer of Health, Halton County Health Unit, Milton, Ontario. 7-81-2

Public Health Nurses (Qualified). Salary range $3.850 - $4,600, required in a generalized program in rural and semi-urban area adjacent to Metropolitan Toronto. Excellent working conditions including pension plan, group insurance, and transportation arrangements. Write: Dr. R. M. King, York County Health Unit, 64 Bayview Avenue, Newmarket, Ontario. 7-84-2

Public Health Nurses (qualified). Salary $3,900 - $4,875. Annual increment $195. Transportation provided, the usual employee benefits. Apply: Dr. C. C. Stewart, Medical Officer of Health, City Hall, 50 Center Street, Oshawa, Ontario. 7-92-2

Public Health Nurses (Qualified) for generalized program with City of Peterborough. Salary range: $3,950-$4,700. Personnel policy available on request. Apply to: J. R. Anderson ,M.D., D.P.H., Medical Officer of Health, City Hall, Peterborough, Ontario. 7-101-3

Public Health Nurses. Salary: $4,000 to $5,000, annual increment $200, allowance for experience. Hospital plan, P.S.I., sick leave, pension plan, 4-wk. vacation, generous car allowance. Nurse will reside in a city of 46,000 pop. Apply: Dr. W. C. MacPherson, Director, Port Arthur and District Health Unit, 93 Balsam St., Port Arthur, Ontario. 7-106-3

Public Health Nurses (qualified) for generalized nursing service. Salary range: $3,800-$4,750 based on experience. Apply to: Dr. J. M. McGarry, M.O.H. St-Catharines-Lincoln Health Unit, St. Catharines, Ontario. 7-111-4

Public Health Nurses (2) for generalized program. Pension, surgical-medical, group ins. and cumulative sick leave plans available. Minimum salary: $3,700 with adjustments for experience. Car provided, or optional choice of mileage plans. Apply to: T. H. Alton, Sec.-Treasurer, Bruce County Health Unit, P.O. Box 70, Walkerton, Ontario. 7-138-2

Public Health Nurses (qualified) for a generalized program in the Township of North York (pop. over 279,000) adjacent to Toronto. Salary range $4,112-$4,704/annum. Starting salary based on previous experience. This is a permanent appointment with excellent employee benefits, car allowance, etc. Apply either by letter or in person to: Personnel Department, 5000 Yonge Street, Willowdale, Ontario. 7-150-1

Staff Nurses for all nursing units of a 325-bed, fully accredited General Hospital located in downtown area. Orientation and in-service program. Rotating hours of duty. Attractive salary & fringe benefits. Apply to: Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto 4, Ontario. 7-133-9

School of Hygiene, University of Toronto. Nurse required for occupational health survey. Applicant should have university degree, industrial experience and a knowledge of research techniques. Salary: $6,000/annum. Applications to: Dr. J. R. Brown, Department of Physiological Hygiene, School of Hygiene, 150 College St., Toronto 5, Ontario. 7-133-68A

BERMUDA

Registered Nurses for Operating Room with operating room postgraduate course and/or experience, for 150-bed hospital. Travel allowance paid. For particulars, write: Matron, King Edward VII Memorial Hospital, Bermuda. 13-1-1B

QUEBEC

Night Supervisor for Shriners Hospital for Crippled Children, excellent personnel policies. Apply: Miss Flora M. Lamont, Administrator, Tel.: 842-4464, Montreal, Que. 9-47-42

Registered Nurses and Certified Nursing Assistants for modern 55-bed General Hospital, salary $320/m, 3 annual increases, 40-hr. wk., 4-wk. vacation. **Certified N.A.** starting salary $220, 3-wk. vacation, accommodation available in new motel-style residence. Apply: Superintendent, Barrie Memorial Hospital, Ormstown, Quebec. 9-52-1A

Operating Room Nurse (General Surgery) to start work Aug. 1st. Must have previous experience or training in this work. Starting salary: $350-$375/m. depending on previous experience. 40-hr. wk. 1 mo. vacation and statutory holidays. Overtime pay. Sickness and other insurance benefits. Please address applications to: Medical Director, Boisvert Memorial Hospital, Baie Comeau, Quebec. 9-7-1

SASKATCHEWAN

Registered Nurses (2) commencing salary $330/m with a deduction of $31/m for room and board, residence on grounds. Apply: William M. Graham, Secy., Climax-Bracken Union Hospital, Climax, Saskatchewan. 10-17-1

Registered Nurse (immediately) for Union Hospital, Mossbank, Sask., with Dr. J. T. Stockings in attendance, salaries as per SRNA with increments and benefits. 40-hr. wk., fully modern nurses' residence, daily bus service to the city. Apply to: Mrs. A. Haug, Matron, Mossbank, Saskatchewan. 10-88-1

Registered or Graduate General Duty Nurses for 25-bed hospital. Salary as per SRNA policy: $310 to $385, room and board: $1.15 per day. 5 day, 40-hr. wk. No split shifts. Evening and night shift with extra pay if out of ordinary rotation. 9 statutory holidays, 3 wk. vacation. Free laundry, modern nurses' residence near hospital with TV — 2 channels. Phone: 2-2668 days, 2-2551 evenings or write: Mrs. Janie Sutherland, Superintendent of Nurses, Union Hospital, Eston, Saskatchewan. 10-33-1

U.S.A.

Registered Nurses for modern 374-bed General Hospital on the beautiful, warm Peninsula yet only 20-min. from the heart of cosmopolitan San Francisco. Openings in all nursing services including operating room, emergency room, and I.C.U. Excellent personnel policies, many extra benefits and opportunities for advancement. Telephone collect, OXford 7-4061 or write: Director of Personnel, Peninsula Hospital, 1783 El Camino Real, Burlingame, California. 15-5-20

Registered Nurses. Career satisfaction, interest and professional growth unlimited in modern, JCAH accredited 254-bed hospital. Located in one of California's finest areas, recreational, educational and cultural advantages are yours as well as wonderful year-round climate. If this combination is what you're looking for, contact us now! Staff Nurse entrance salary $370 with automatic increases to $435 per mo., supervisory positions at increased rate. Special area and liberal shift differentials paid. Excellent benefits including Blue Cross hospitalization and surgical coverage and liberal personnel policies. Professional staff appointments available in all clinical areas to those eligible for California licensure. Write today: Director of Nursing, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, California. 15-5-12

Registered Nurses for new 86-bed JCAH approved privately owned hospital, San Francisco Bay Area. Positions available in Operating Room, Medical and Surgical Units. Staff Nurses entrance salary $390 - $410, plus special area, evening and night differential paid. Free Blue Cross Hospitalization and surgical coverage, also State Disability Insurance, with liberal personnel policies and fringe benefits. Uniforms laundered free. Excellent modern housing, schools and colleges. Apply: Director of Nursing, Laurel Grove Hospital, 19933 Lake Chabot Road, Castro Valley, California. 15-5-12A

Registered Nurse for private practice in southern California. Starting salary **$385.** Must report for work no less than 60 days. Contact Mrs. Martin, 10720 S. Paramount Blvd., Downey, California. 15-5-18

Registered Nurses, Staff Nurses for permanent positions, various departments, days, eves., nights. Excellent starting salary, increments, benefits and working conditions in one of the largest and finest general hospitals in the West. For details write: Personnel Department, Queen of Angels Hospital, 2301 Bellevue Avenue, Los Angeles 26, California. 15-5-3G

Registered Nurses for private 258-bed hospital for men, women and children. Staff Nurse salaries from $355-$435, differentials for evenings, nights, communicable disease, operating room and delivery. Opportunities in all clinical areas. Holidays, vacations, sick leaves and health insurance. California registration required. Applications and details furnished on request. Contact: Personnel Director, Children's Hospital, 3700 California Street, San Francisco 18, California. 15-5-4

Registered Nurses for 233-bed modern hospital. Positions available — all services, no shift rotation. Liberal benefits, advancement opportunities, educational opportunities in area, equal opportunity employer. Apply: Director of Nursing Service, Kaiser Foundation Hospitals, San Francisco 15, California. 15-5-7

Registered Nurses (Prefer applicants with some knowledge of English) for 350-bed hospital, openings in Southern California, Ventura, located between Santa Barbara and Los Angeles, city of 34,000 ideal year around climate and varied recreational facilities. Salary $366 - $445/m. Nurses' quarters $10/m. Write: Personnel Department, Court House, Ventura, California. 15-5-7

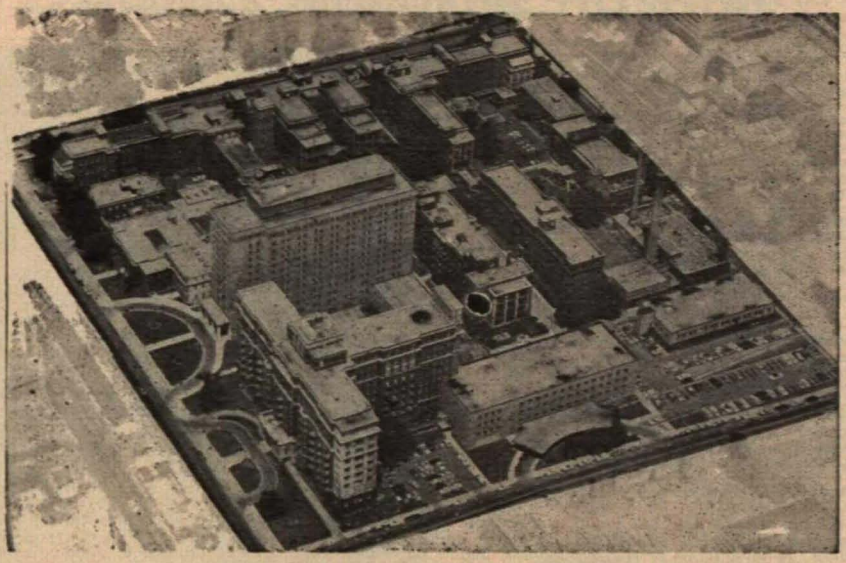
Registered Nurses and Certified Nursing Assistants for new, modern hospital owned and operated by the Daughters of Charity, located in the heart of Santa Clara Valley, 1 hr. from San Francisco, close to beaches and mountains. Needed immediately, Nurses for all tours of duty in all services, particularly O.B. and O.R. Excellent geographical location, climate, working environment contribute to your job satisfaction. Apply: Director of Nursing Service, O'Connor hospital, San Jose, California. 15-5-10

REGISTERED NURSES for General Duty in 350-bed General Hospital. Good salary, excellent increments and benefit program, ideal climate. **APPLY: Personnel Department, St. Mary's Hospital, Long Beach, California.** 15-5-32

Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Starting salary $375 per mo. plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California. 15-5-39

Attention! General Duty Nurses 300-bed fully accredited County Hospital located 2-hr. drive from San Francisco, ocean beaches and mountain resorts in modern and progressive city of 35,000. 40-hr. 5-day wk., pd. vacation, pd. holidays, pd. sick leave, retirement plan, social security and insurance plan. Accommodations in nurses' home, meals at reasonable rates, uniforms laundered without charge. Starting salary $395 per mo., plus shift and service differentials. Merit increase to $458/m. Must be eligible for California registration. Write: Director of Nursing, Stanislaus County Hospital, 830 Scenic Drive, Modesto, California. 15-5-42

TORONTO GENERAL HOSPITAL



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Modern General Hospital, located in the Garden City of Canada, adjacent to American Cities and close to Toronto and Hamilton.

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General Duty Staff Nurses for large General Hospital, located in college community, central California. Starting salary: $413 per mo. Excellent in-service education program, liberal fringe benefits, shift differential. Apply: Personnel Director, 530 Courthouse, Stockton, California. 15-5-36

Staff Duty positions (Nurses) in private 428-bed hospital. Liberal personnel policies and salary. Differential for evening and night duty. Write: Personnel Director, Hospital of The Good Samaritan, 1212 Shatto Street, Los Angeles 17, California. 15-5-3B

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon and night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California. 15-5-3C

Nurses for new 75-bed General Hospital. Resort area. Ideal climate. On beautiful Pacific ocean. Apply to: Director of Nurses, South Coast Community Hospital, South Laguna, California. 15-5-50

Professional Nurses for immediate openings in 274-bed General Hospital, liberal fringe benefits. Enjoy interesting, challenging position in the ideal climate of Santa Monica Bay. Apply: Director of Nursing, Santa Monica Hospital, 1250-16th Street, Santa Monica, California. 15-5-40

Executive Director generalized public health nursing agency. Potential for program expansion in rapidly growing community 45 minutes from NYC. Staff 8 full time, 5 relief nurses. Master's degree, administrative ability; experience required, salary open. Send résumé to Mr. Charles H. Ulrich, Chairman, Personnel Committee, Visiting Nurse Association, 60 Guernsey Street, Stamford, Connecticut. 15-7-4

General Duty Nurses for 54-bed hospital, minimum starting salary $350 per mo., located near Miami and West Palm Beach. Apply: Director of Nurses, Belle Glade Memorial Hospital, Belle Glade, Florida. 15-10-3

Registered Nurses for 74-bed air-conditioned hospital, growing community. Starting salary: $330 per mo., fringe benefits, vacation, sick leave, holidays, life insurance, hospital insurance, 1 meal furnished. Write: Hendry General Hospital, Clewiston, Florida. 15-10-1

Staff Nurses (All Areas) Orientation and staff development programs, "nurse-saving" equipment, challenging working environment, individualized living accommodations in new air-conditioned cottages. Opportunity to participate in nursing practice of the finest quality in our 200-bed General Hospital, located along Lake Michigan shoreline, 30 mi. from Chicago. Starting salaries $390-$410 plus $30 differential for 3-11 and 11-7. Write: Director of Nursing, Highland Park Hospital, Highland Park, Illinois, for detailed brochure. 15-14-3

Graduate Nurses (Professional) — Want to be a Mount Sinai Nurse? Choose a career that counts at Chicago's Mount Sinai Hospital. Various staff and special assignments. Starting salary to $440 with experience, plus $50 evening differential. $40 nights and premiums for special assignments. Liberal fringe benefit program including vacation to 4-wk. per year; 8 paid holidays; cumulative sick leave, etc. Private rooms in modern residence. Write: Director of Nursing Services, Dept. CJN, Mount Sinai Hospital, Chicago 8, Illinois. 15-14-1C

Staff Nurses and Licensed Practical Nurses (Openings in several areas, all shifts). Minimum starting pay $77 R.N.'s; L.P.N.'s $61 per wk., experience considered, differentials paid for reliefs, nights. Every other weekend off in small community hospital 2 miles from Boston. Living quarters available. Contact: Miss Elizabeth B. Kennedy, R.N., Director of Nursing, Chelsea Memorial Hospital, Chelsea, Mass. 15-22-1

Registered Nurses for 277-bed General Hospital conveniently located to downtown Detroit and Northland Shopping Center. Starting salary range from $391 - $421 depending upon previous experience. Liberal personnel policies. Write to: Director of Nursing, Highland Park General Hospital, Highland Park 3, Michigan, or call TO. 8-5140. 15-23-3

Staff Nurses 380-bed hosp. new 120 med-surg. unit. Trans. pd. 1st class air to Albuq. and return within U.S. in exchange for 1-yr. emp. contract. Come to New Mexico "Land of Enchantment." Career opportunities, largest pvt. JCAH accredited hosp. in state; near U. of New Mexico. R.N. & B.S. pgm. Practical Nurse pgm. accredited state & NAPNE. Vacancies, Med-Surg. & occasionally O.B., Peds., & O.R., salaries $315 per mo. even., night or O.R. with call; 6-mo. increases up to $375; days $300 per mo. with increases up to $360. Rotation from day duty is required only when no person desiring permanent P.M. of night tour is available. Liberal personnel policies include: optional Blue Cross, Discount Hosp. Services, pd. sick leave cumulative to 5 wks., annual physical exam., vacation 1 yr. — 2 wks., 2 yrs. — 3 wks., 5 yrs. — 4 wks. Active in-service pgm. Occasional vacancy hosp. owned apts. New Mexico licensure as professional nurse & U.S. Citizenship (or Immigration Visa) required. Write or call collect: Mrs. Emily J. Tuttle, Dir. of Nursing, Presbyterian Hospital Center, 1012 Gold, S.E., Albuquerque, New Mexico. Phone 243-5611. 15-32-3

Graduate Nurses for 450-bed non-sectarian acute General Hospital with NLN fully accredited school of nursing. Liberal personnel policies include tuition aid for study at Western Reserve University. Opening of new main building has created attractive positions for Staff Nurses in medical, surgical, obstetric and pediatric divisions. Apartments available in immediate neighborhood. Apply: Miss Louise Harrison, Director of Nursing Service, Mount Sinai Hospital, 1800 East 105th Street Cleveland 6, Ohio. 15-36-1D

Staff Nurses for modern 400-bed tuberculosis hospital, suburban Cleveland, Ohio. Monthly salaries start at $396 with semi-annual increments. Extra for night and relief duty, 5-day work wk., 3-wk. paid vacation, 6 paid holidays, liberal sick leave, comfortable accommodations in nurses' residence at low rate. Learn and earn at a progressive accredited hospital in a growing community. Write: Director of Nursing, Sunny Acres Hospital, Cleveland 22, Ohio. 15-36-1E

Registered Nurse (Scenic Oregon, vacation playground, skiing, swimming, boating & cultural events) for 295-bed teaching unit on campus of University of Oregon medical school. Salary starts at $372. Pay differential for nights & evenings. Liberal policy for advancement, vacations, sick leave, holidays. Apply: Multnomah Hospital, Portland 1, Oregon. 15-38-1

Staff Nurses (All Clinical Services) Base salary $350, opportunities for advancement, differential for 3-11 & 11-7 shifts, personnel policies, sick leave, retirement plan, 3-wk. vacation & laundry of uniforms. Orientation & in-service programs, housing available on campus Apply: Director of Nursing Service, University of Texas Medical Branch Hospitals, Galveston, Texas. 15-44-5

ASSISTANT DIRECTOR NURSING SERVICES(NIGHTS) for modern 314-bed teaching and research hospital located on beautiful university campus. Salary $487 - $653. Liberal fringe benefits, free educational opportunities after six months. Apply: Hospital Personnel, BB-314, University Hospital, University of Washington, Seattle, Washingon. 15-48-2E

General Duty Nurses for 232-bed General Hospital; university city; needs 3-11 and 11-7 shift nurses, salary $380-$420 and $375-$415/m respectively, excellent benefits, including medical and life insurance. Extensive intern-resident educational program. Free quarters available the first month. Must have psychiatric training to obtain a Washington nursing licence. Write Personnel Manager, Virginia Mason Hospital, 1111 Terry Avenue, Seattle 1, Washington. "Work in Seattle and enjoy moderate winters and comfortable summers." 15-48-2B

Staff Nurses — University Hospital wants you if you want a challenging and rewarding position in a modern expanding 320-bed teaching and research hospital located on campus. Salary $375-$439/m. Opportunities in clinical research, premature center, chronic renal program, open heart surgery, and physical medicine, in addition to the general services. Liberal benefits including tuition free courses after six months. Contact: University Hospital, 1959 Pacific Avenue, Seattle, Washington. 15-48-2D

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Modern 900-bed hospital

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Registered Nurses for all services

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40 hour week - Pension plan - Good salaries and Personnel Policies.

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RESIDENCE ACCOMMODATION AVAILABLE

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Clinical Instructor qualified on or before July 1, 1963, student body approximately 130, salary commensurate with qualifications and experience, excellent policies, O.H.A. Pension Plan.

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An open letter to Canadian nurses. Grant Hospital of Chicago, Ill. offers to Canadian registered nurses positions as medical-surgical staff or psychiatric staff nurses. Grant is a 300-bed general hospital exemplifying the finest in techniques and equipment including a recently opened $3,500,000 new pavilion which is centrally air-conditioned. We start day staff nurses at $400 per month with a generous differential for evenings and nights: there are regular increases. Psych. nurses start at $416 per month, again with shift differential and, for all nurses, there is no rotation of shifts. The hospital is located in an interesting middle class neighborhood just 2 and 4 blocks respectively from famed Lincoln Park and Lake Michigan. Fine living accommodations are limitless. Educational and recreational facilities are intriguing, latter particularly so for the single man and woman. Apply to the Director of Nursing, Grant Hospital of Chicago, 551 W. Grant Place, Chicago 14, Ill.

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requires a

PUBLIC HEALTH NURSE

Must be a Registered Nurse with a public health certificate

5 day - 36 1/4 hour week
Minimum salary : $3,858
Maximum salary : $4,588

Starting salary commensurate with previous experience

Top fringe benefits including pension, sick pay, group insurance, vacations, statutory holidays, hospital and medical plan

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Office Nurse: R.N. who has specialized in career office nursing to take over full nursing responsibilities in large solo neighborhood general practice. Age 25-40. Previous office expeirence. Job includes X-ray and some lab., maybe assist in surgery. Pleasant working conditions. Unlimited opportunity for advancement. Career position. Pacific northwest city of 200,000 with full outdoor recreational facilities. Write, 2034 Manito Place, Spokane, Washington. 15-48-1A

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(650 beds)

University preparation and experience at an advanced level required.

Please apply to:

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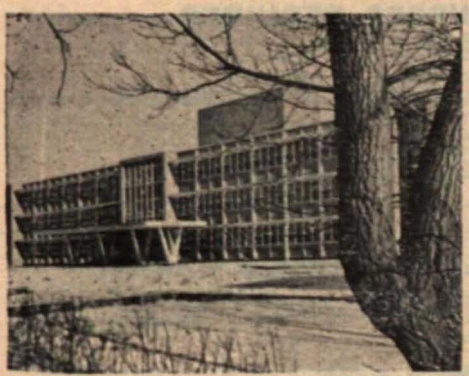

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GALT, ONTARIO

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SALARY $320 — $350 PER MONTH

Rotating Shifts — 28 days vacation after one year of service — O.H.A. — P.S.I. — Life insurance 50% paid by hospital

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3. PEDIATRIC ASSISTANT SUPERVISOR
4. MATERNITY ASSISTANT SUPERVISOR

Salary commensurate with qualifications and experience.

For further information please apply:

DIRECTOR OF NURSING
KINGSTON GENERAL HOSPITAL, KINGSTON, ONTARIO

REGISTERED NURSES REQUIRED

For General Duty in modern 18-bed private Hospital in Iron mining town, 140 miles north of Sault Ste. Marie, Ontario.

SALARY RANGE $310 MINIMUM TO $360 MAXIMUM

Allowance for experience. Board and room available at $20 per month. Transportation allowance up to $50 after 6 months.

Apply:

SUPERINTENDENT OF NURSES
LADY DUNN HOSPITAL, WAWA, ONTARIO

POSITIONS OPEN — REGISTERED NURSES

Starting Salary $330 per month - Allowance for experience - Enquiries invited - Personnel Policies on request - 40 Hour Week - 9 statutory Holidays - Room and Board - Nurses' Residence $45 per month New Hospital to be completed very soon

Apply to: **Mrs. G. AUGER**

DIRECTOR OF NURSING, LITTLE LONG LAC HOSPITAL, GERALDTON, ONTARIO

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REQUIRED FOR HEALTH BRANCH, B.C. CIVIL SERVICE

Positions available for qualified Public Health Nurses in various centres in British Columbia. SALARY: $375 - $462 per month; car provided. An opportunity for interesting and challenging professional service in this beautiful and fast-developing Province. For further information and application forms, apply to The Director, Public Health Nursing, Department of Health Services and Hospital Insurance, Parliament Buildings, Victoria, B.C., or to The Chairman, B.C. Civil Service Commission, 544 Michigan Street, Victoria, B.C.

COMPETITION No. 63:101

THE SCARBOROUGH GENERAL HOSPITAL

A new modern hospital located 10 miles from downtown Toronto invites applications from:

REGISTERED NURSES
REGISTERED NURSING ASSISTANTS

Opportunities are offered in Supervisory, Head Nurse and General Duty positions. Services are offered in Medicine, Surgery, Obstetrics, Pediatrics, Emergency and Intensive Care Units.

Salaries commensurate with prevailing current salaries for Nurses in Metropolitan Toronto and adjustable with experience and educational qualifications.

Progressive Personnel Policies, Pension Plan, Orientation and In-service Program.

For further information write to:

DIRECTOR OF NURSING
SCARBOROUGH GENERAL HOSPITAL, SCARBOROUGH, ONTARIO

THE GENERAL HOSPITAL OF PORT ARTHUR

Invites applications for the position of

ASSISTANT DIRECTOR OF NURSING SERVICE

SALARY COMMENSURATE WITH QUALIFICATIONS AND EXPERIENCE

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GENERAL HOSPITAL OF PORT ARTHUR
PORT ARTHUR, ONTARIO

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invites applications for

Assistant Director of Nursing (Service)

AVAILABLE SEPTEMBER 2ND

Salary commensurate with preparation and experience as recommended by the Association of Nurses of the Province of Quebec.

Active modern General Hospital, 150 beds. Long established School of Nursing. Excellent personnel policies. 100 miles from Montreal, easily accessible by bus and rail.

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in modern 20-bed hospital located in thriving Northwestern Ontario community. Starting salary $275 minimum to $325 maximum for three years' experience. Board and room in modern nurses' residence is supplied at no charge. Excellent employee benefits and recreational facilities available. Further particulars on request.

Apply, giving full details of experience, age, availability, etc., to:

EMPLOYMENT SUPERVISOR,
Marathon Corporation of Canada Limited, Marathon, Ontario.

CLASSROOM AND CLINICAL INSTRUCTOR

required for

THE HOSPITAL FOR MENTAL DISEASES, BRANDON, MANITOBA

Salary schedule: $4,200-$5,280 per annum - Regular annual increments - Pension privileges - Liberal sick leave with pay - Annual vacation with pay - Duties to commence immediately
Qualifications: Instructor with Psychiatric experience preferable.

Apply to:

THE DIRECTOR OF NURSING, HOSPITAL FOR MENTAL DISEASES, BRANDON, MAN.

Applications are invited for the position of

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OF THE NEW BRUNSWICK ASSOCIATION OF REGISTERED NURSES

QUALIFICATIONS:

R.N., preferably bilingual, mature, with leadership ability and desirable personable qualities enabling her to establish good relationships; interested in public speaking and writing; post-basic education desirable.

SALARY NEGOTIABLE.

Apply to:

The President,
THE N.B. ASSOCIATION OF REGISTERED NURSES
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OPERATING ROOM SUPERVISOR

REQUIRED

200-bed General Hospital fully accredited
Pleasant City — 3 colleges
Good salary and personnel policies

For further information apply to:

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Guelph, Ontario.

INSTRUCTORS

MEDICAL-SURGICAL NURSING

This is an opportunity to participate in the development of a progressive School of Nursing. **Student enrollment of 300 — New School of Nursing, Medical and Surgical Units just completed.**

Duties include classroom and clinical instruction in certain areas of an integrated course in Medical-Surgical Nursing.

Requirements: University preparation in Nursing Education.

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JEFFERY HALE'S HOSPITAL

in

BEAUTIFUL QUEBEC CITY

GENERAL DUTY NURSES

MODERN 161-bed General Hospital (Non-Sectarian)

Apply:

MISS K. MARSHALL, DIRECTOR OF NURSING,
School of Nursing, 1250 Ste. Foy Road, Quebec 6, Que.

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OPERATING ROOMS

required by

UNIVERSITY OF ALBERTA HOSPITAL

EDMONTON, ALBERTA

Applications are invited for the above position. Benefits include group insurance, pension plan, sick leave allowance etc. Salary credit allowed for preparation and previous experience.

For further information, apply:

Director of Nursing,
UNIVERSITY HOSPITAL,
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DIRECTOR OF NURSING

KENORA, ONTARIO

This resort town of 14,000 people has a new 100-bed hospital located on the shores of beautiful Lake of the Woods in Ontario. In the summer we have swimming, boating, fishing and golfing. In the winter there is skating, curling, tobogganing, skiing and ice fishing.

A two-room suite with private facilities is available in our nurses' residence at a reasonable fee of $20 per month. There are personnel policies governing all staff of the hospital and the nursing director will come under a private contract.

Salary is negotiable.

Excellent opportunity for any registered nurse interested in nursing administration.

Please reply to:

Mr. A. C. DUNCAN
Administrator
KENORA GENERAL HOSPITAL
KENORA, ONTARIO

CLINICAL AND CLASSROOM INSTRUCTOR

with advanced preparation required for August, 1963

APPROVED SCHOOL OF NURSING

Junior students attend Lakehead College for instruction in the basic physical and social sciences and English.

Fully accredited hospital — 300-beds. This is one of the loveliest parts of Canada, and is both a summer and winter sports resort.

For further information write to:

THE DIRECTOR OF NURSING
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Continuing and temporary appointments

for

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are currently available. Full range of employee perquisites with month salary of $325 ($341 for two years of experience) rising to $374 per month.

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THE VANCOUVER GENERAL HOSPITAL
10th AND HEATHER,
Vancouver, B.C.

REGISTERED NURSES

and

CERTIFIED NURSING ASSISTANTS

for

360-bed accredited General Hospital. Registered Nurses salary range $315-$355 per month with consideration for contemporary experience or special preparation.

Certified Nursing Assistants $210 - $240 per month.

For further information write:

Director of Nursing Service
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Windsor, Ontario.

NURSING OFFICE SUPERVISOR

Required for 321-bed Medical and Rehabilitation Unit with expansion program. University preparation in administration of Nursing Service and experience essential.

Monthly salary with diploma $407.30 to $476.60

Monthly salary with degree $416 to $485.30

Good personnel policies.

Position available for late summer.

Apply to:

SUPERINTENDENT OF NURSES,
Division "H",
Henderson General Hospital,
Hamilton, Ontario.

NURSES

KENORA, ONTARIO

This resort town of 14,000 people has just opened a section of its new 100-bed hospital and in the not too distant future will be opening the second section for which nurses are needed. The hospital is wonderfully located on the shores of beautiful Lake of the Woods in Ontario. In the summer we have activities in swimming, boating, fishing and golfing and in the winter there is skating, curling, tobogganing, skiing and ice fishing.

A nurse's residence is available at a reasonable rate of $20 per month for private room or $15 per month for a double room. Cafeteria services are available at cost as well as a kitchen in the nurses' residence. Separate personnel policies for nurses are available and will be mailed on request. The starting salary is $315 per month. Eight statutory holidays, sick leave, three weeks vacation with pay are some of the benefits of these policies.

All applications will be treated with courtesy and privacy.

Please apply to:

Administrator
Mr. A. C. DUNCAN
KENORA GENERAL HOSPITAL
KENORA, ONTARIO

ST. JOSEPH'S HOSPITAL

Toronto, Ontario

REGISTERED NURSES

and

CERTIFIED NURSING ASSISTANTS

600-bed fully accredited hospital provides experience in Operating Room, Recovery Room, Intensive Care Unit, Pediatrics, Orthopedics, Obstetrics, General Surgery and Medicine.

Orientation and Active In-service program for all staff.

Salary is commensurate with preparation and experience.

Benefits include Pension Plan, Group Life Insurance, Sick Leave — 12 days after one year, Ontario Hospital Insurance — 50% payment by hospital.

Rotating Periods of duty — 40 hour week, 8 statutory holidays — annual vacation 3 weeks after one year.

Apply

ASSISTANT DIRECTOR OF NURSING SERVICE
ST. JOSEPH'S HOSPITAL
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AVAILABLE

in the General Operating Rooms (includes general surgery, cardiac, neurosurgery, plastic, ear, nose and throat and urology), Gynecological and Ophthalmological operating rooms. Salary commensurate with experience. Opportunities for promotion. Excellent fringe benefits including refund of tuition up to six points per semester.

For further information write:

DIRECTOR, NURSING SERVICE
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with Postgraduate Course in Operating Room Technique and Management.

Required for

375-bed accredited General Hospital. Salary range $350 - $390 per month. Fringe benefits include hospital and medical coverage, generous sick leave, three weeks vacation, and contributory pension plan.

For further information write:

Director of Nursing Service,
METROPOLITAN GENERAL HOSPITAL,
Windsor, Ontario.

UNIVERSITY HOSPITAL

EDMONTON, ALBERTA

requires

REGISTERED NURSES

for Operating Room Duty. Excellent working conditions in newly completed services building. Salary schedule $300 to $360 per month. Credit for previous experience and graduate training.

For further details apply to:

MISS M. J. LEES
Associate Director of Nursing Service

WANTED

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Positions for undergraduate Schools of Nursing at Ontario Hospitals, Brockville, Kingston and Whitby.

Applicants required to have postgraduate Certificate in Nursing Education or B.Sc.N. degree.

Salary range $4,200 to $5,000. Opportunity for promotion or appointment to higher classifications depending on experience and training.

Living accommodation and meals at nominal rates if desired.

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WHITBY

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The McKellar General Hospital wants Registered Nurses and is willing to prepay costs of transportation for those nurses remaining on staff for one year. Basic salary for Registered Nurses — $325 per month. Good residence accommodation is available. "The Hospital and the Community are friendly."

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GUELPH GENERAL HOSPITAL

Active — 200 beds — Fully accredited

requires

GENERAL STAFF NURSES

Pleasant city of 40,000 close to larger centers. Good personnel policies.

For further details apply to:

THE DIRECTOR OF NURSING
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OTTAWA CIVIC HOSPITAL

requires

GENERAL STAFF NURSES

for

OPERATING ROOM
MEDICAL
SURGICAL
OBSTETRICAL AND
PSYCHIATRIC
} DEPARTMENTS

Apply

EDITH G. YOUNG, REG. N.,
Assistant Director and Administrator of the Department of Nursing

ROSS MEMORIAL HOSPITAL

requires

GENERAL DUTY NURSES

for

MEDICAL, SURGICAL, PEDIATRICS DEPARTMENTS

Good personnel policies. O.H.A. Pension Plan

Enquire:

DIRECTOR OF NURSING
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NURSING COUNSELLORS
$4,140 - $4,590

DEPARTMENT OF NATIONAL HEALTH AND WELFARE, OTTAWA

The appointees will be required to provide health counselling and guidance to federal government employees. A diploma in Public Health Nursing and at least one year of acceptable experience is required.

For further information, write immediately to

THE CIVIL SERVICE COMMISSION
OF CANADA - OTTAWA 4
Ask for Information Circular 63-589

INSTRUCTORS

for

SCIENCE
SURGICAL-CLINICAL
O.R. CLINICAL

University preparation required

Salary differential for degree

For further information apply to:

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BRANDON GENERAL HOSPITAL
Brandon, Manitoba

REGISTERED NURSES

AND

OPERATING ROOM NURSE

required for:

82-bed hospital. Situated in the Niagara Peninsula. Transportation assistance.

For salary rates and personnel policies apply to:

DIRECTOR OF NURSING
Haldimand War Memorial Hospital
Dunnville, Ontario

GENERAL DUTY NURSES

for

Chest Hospital in centre of Montreal
Good Personnel Policies

Apply:

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ROYAL EDWARD LAURENTIAN HOSPITAL
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THE McKELLAR GENERAL HOSPITAL

SCHOOL OF NURSING

will require the following instructors in the summer of 1963:

(1) Basic Nursing Instructor
(1) Surgical Nursing Instructor
(1) Medical Nursing Instructor
(1) Medical-Surgical Instructor

Salary scale is good and so are the Personnel Policies.

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McKELLAR GENERAL HOSPITAL
FORT WILLIAM, ONTARIO.

SUPERVISOR

for

Large and active operating room.

Salary commensurate with experience and qualifications.

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Associate Director, Nursing Service
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Regina, Saskatchewan

QUEEN ELIZABETH HOSPITAL

OF MONTREAL

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Salary commensurate with experience and preparation. Position available — August 15th, 1963.

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ROYAL INLAND HOSPITAL
Kamloops, B.C.

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KENTVILLE, N.S.

Offers to Graduate Nurses a Three-Month Course in *Tuberculosis Nursing*, including Immunology, Prevention, Medical and Surgical Treatment.

1. Full series of lectures by Medical and Surgical staff.
2. Demonstrations and Clinics.
3. Full maintenance, salary and all staff privileges.

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NOVA SCOTIA SANATORIUM
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offers a varied experience to

OPERATING ROOM NURSES

For further information apply to:

DIRECTOR OF NURSING
THE MONTREAL GENERAL HOSPITAL
1650 Cedar Avenue, Montreal 25, Que.

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for

110-bed "HOME FOR THE AGED" with 50-bed bed-care wing. Located on Grand River, Niagara Peninsula within 1 hour's travel to Hamilton, Niagara Falls and Buffalo, N.Y. Modern staff quarters optional.

For full particulars apply:

SUPERINTENDENT
stating qualifications, experience and remuneration
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School of Nursing

Degree Course in Basic Professional Nursing

Candidates for the degree of Bachelor of Nursing are required to complete 2 years of university work before entering the clinical field, and one year of university work following the basic clinical period of 30 months. On completion of the course the student receives the **Degree** of Bachelor of Nursing and the **Professional Diploma** in either Teaching in Schools of Nursing or Public Health Nursing.

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Graduate nurses who wish to obtain the degree of Bachelor of Nursing are required to complete the three years of university work.

Diploma Courses for Graduate Nurses

(a) Public Health Nursing
(b) Teaching in Schools of Nursing
(c) Nursing Service Administration

For further information apply to:

DIRECTOR, SCHOOL OF NURSING
DALHOUSIE UNIVERSITY, HALIFAX, N.S.

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SCHOOL OF NURSING

in cooperation with

UNIVERSITY HOSPITAL

PROGRAMS FOR GRADUATE NURSES

Teaching and Supervision. **To prepare for positions in teaching and supervision in Schools of Nursing.**

Public Health Nursing. **To prepare for staff positions in all types of public health nursing agencies.**

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Credits earned may be applied toward the degree of Bachelor of Science in Nursing.

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Bachelor of Science in Nursing. **Students with senior matriculation may enroll in a combined academic and professional program.**

Diploma in Nursing. **The School also conducts a three-year hospital program.**

For further information apply to:

DIRECTOR, SCHOOL OF NURSING,
UNIVERSITY OF SASKATCHEWAN,
SASKATOON, SASKATCHEWAN

UNIVERSITY OF BRITISH COLUMBIA

School of Nursing

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DEGREE COURSE FOR GRADUATE NURSES

Both of these courses lead to the B.S.N. degree. Graduates are prepared for public health as well as hospital nursing positions.

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1. **Public Health Nursing.**
2. **Administration of Hospital Nursing Units.**

For information write to:

The Director, SCHOOL OF NURSING
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VANCOUVER 8, B.C.

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JULY 1963

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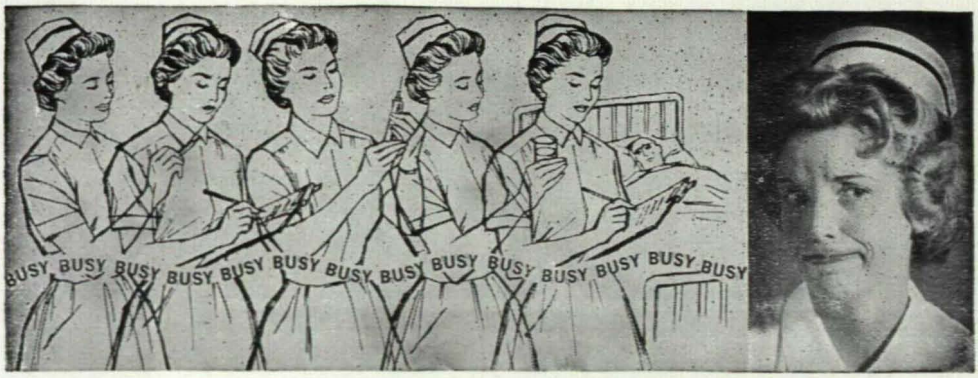

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Each tablet contains:

Phenolphthalein	¾ gr.
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Ipecac powder	1/16 gr.

DOSAGE: One or two tablets at bedtime. In obstinate cases, one tablet after each meal, then reduced to one morning and night. After regularity has been established, one or two tablets each night until condition is corrected.

Tubes of 25, bottles of 100 tablets

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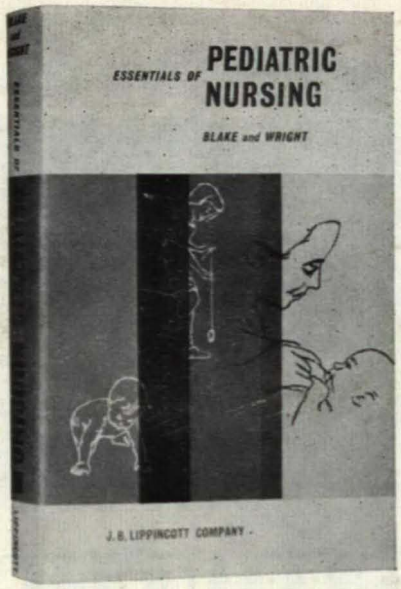

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Reorganized and rewritten to:

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• place developmental and medical aspects into closer relationship in each age period under discussion.

• Deepen understanding not only of health problems, but also the varied meanings which deviations from normality may have for children and their parents.

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Lippincott

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